

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 108640

1. PLACE OF DEATH

County... Balt Co
 City or town... Hyde
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Balt.
 City or town... Hyde
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Martha J. Allender

3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Wid.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 26 - 1850

6. (c) If alive, give age _____ years

8. AGE:

Years 97

Months 6

Days _____

If less than one day _____

hrs. _____

min. _____

9. Birthplace

Md.
 (Town, county, and state)

10. Usual occupation

None

11. Industry or business

MOTHER FATHER

12. Name

George Pearce

13. Birthplace

Md.

14. Maiden name

Unknown

15. Birthplace

11

16. Informant

Letitia Hagan

Address

Hyde Md.

17.

(Burial, cremation, or removal, which)

Date thereof

Dec. 29 - 47

Cemetery or crematory

St. Johns Cem.

Location

Fondren Md.

18. Funeral director

Charles E. Arthur

Address

Fork Md.

19.

(Date rec'd by registrar)

Dec. 26 1947

C. E. Arthur

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1947 at 9 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1940 to December 24 47

and that I last saw her alive on December 24 1947

Immediate cause of death Cerebral Hemorrhage DURATION 4 day

Arteriosclerosis years

Due to _____

Due to _____

Other conditions Arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Nathan Hammitt M. D. or other _____

Address Baltimore Date signed 12/27/47

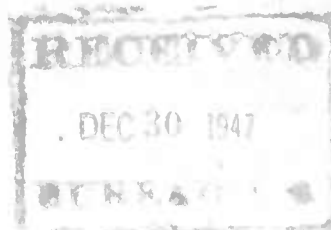
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I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

10865

1. PLACE OF DEATH

County BaltimoreRegistration Dist. No. 38Village or City AnneslieNo. 6510 Banbury Rd.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 10 yrs. mos. ds.

How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME NAPOLÉON ALZINGRE(a) Residence: No. 6510 Banbury Rd.

St. Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Widowed

5a. If married, widowed, or divorced

HUSBAND of
(or) WIFE ofunknown

6. DATE OF BIRTH (month, day, and year)

October 10, 1859

7. AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.88128

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation

12. BIRTHPLACE (city or town)

Mass.

(State or country)

FATHER

13. NAME

unknown

MOTHER

14. BIRTHPLACE (city or town)

unknown

(State or country)

15. MAIDEN NAME

unknown

16. BIRTHPLACE (city or town)

unknown

(State or country)

17. INFORMANT

Mr. Charles S. White Jr.

(Address)

6510 Banbury Rd. Balto. 12, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place St. Margarets, Md. Date 12-10-47, 19

19. UNDERTAKER

Ben L. Hopping and Son

(Address)

170-172 West St. Annapolis, Md.

20. FILED

Dec. 10 1947 Wm. J. French
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

December 8

(Month)

(Day)

1947
(Year)

22.

I HEREBY CERTIFY, That I attended deceased from

July1939

to

Dec1947I last saw him alive on 6 Dec, 1947; death is saidto have occurred on the date stated above, at 11 P. m.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:

Date of onset

Arterio-sclerotic
Cardio-Vascular disease 1946

Other Contributory Causes of importance:

Name of operation

none

Date of

What test confirmed diagnosis?

none

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed)

Charles H. Rein

M. D.

(Address)

6701 York Rd. Balto. 12, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>DEC 11 1947</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 10866
 Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
 How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 709 Franklin Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I

3. (a) FULL NAME

JOHN S. ASHBY

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife Single
 7. Birth date of deceased (mo., day, yr.) 12-25-91
 6.(c) If alive, give age _____ years

8. AGE: Years 55 Months 11 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Cape Charles, Va.
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business _____

MOTHER FATHER
 12. Name Sam Ashby
 13. Birthplace North Carolina
 14. Maiden name Margaret Drickers
 15. Birthplace Virginia

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Md.

17. Burial Date thereof 12-18-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
Baltimore, Maryland
 Location _____

18. Funeral director A. Halstead
 Address 918 Druid Hill Ave., Balto., Md.

19. Dec. 18, 47 A.W. Hedrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 1947 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 7, 1947 to December 13, 1947
 and that I last saw him alive on December 13, 1947

Immediate cause of death
Coronary Arteriosclerotic Heart
Disease DURATION 1 Yr. Plus

Due to _____

~~See~~ Other Cond: Mural Thrombus, rt. auricle; Duration: Unknown
Infarct, rt. lower lobe lung, Duration: Recent
Hydrothorax, bilat. Moderate
Duration: Unknown. Infar ct, Rt. kidney
 (Include pregnancy within 3 months) Duration: Old.

Major findings of operations _____ Date of op. _____

Autopsy results Substantiated above.
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert L. Larnier
R. L. LARNER, M.D. M. D. or other
 Address V.A.H. FORT HOWARD, MD. Date signed 12-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ✓

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10867

Reg. Dist. No. 35

1. PLACE OF DEATH:

County BaltimoreCity or town White Hall
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 70 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore City or town White Hall
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Robert Semmill Bacon

3. (b) Social Security Number

NONE

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Annie Almony

7. Birth date of

deceased (mo., day, yr.)

Nov. 7. 1862

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

8515

hrs.

min.

9. Birthplace

Monkton, Md

(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

FATHER

12. Name

William Bacon

13. Birthplace

unknown

MOTHER

14. Maiden name

Martha

15. Birthplace

unknown

16. Informant

Mrs. Annie Bacon

Address

White Hall, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Dec. 15-1947
(month) (day) (year)

Cemetery or crematory

Union

Location

White Hall, Md

18. Funeral director

Howard S. Markline

Address

White Hall, Md

19. Dec. 13, 47

(Date rec'd by registrar)

Mrs. Howard S. Markline

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 19 47 at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 9 19 47 to Dec 12 19 47
and that I last saw him alive on Dec 12 19 47

Immediate cause of death

Coronary Occlusion

DURATION

9 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

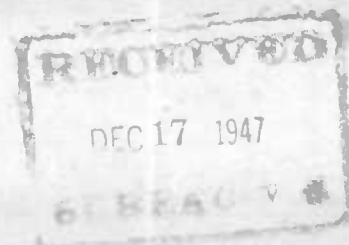
23. SIGNATURE

William Portner M.D.

M. D. or other

Address

White HallDate signed Dec 13, 47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10869

Reg. Dist. No. 241

1. PLACE OF DEATH:

County Balto.
City or town Sparks Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto.City or town Dundalk 22
(If outside city or town limits, write RURAL and give nearest town)Street No. 1810 East ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married.

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

46

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

Scotland

(Town, county, and state)

10. Usual occupation

Fireman

11. Industry or business

Bethlehem Steel Co

12. Name

Wm R Bell

13. Birthplace

Scotland

14. Maiden name

Margaret Rogers

15. Birthplace

Scotland

16. Informant

Mrs J Bell

Address

1810 S. East Ave Dundalk 22

17.

Burial

Date thereof

Dec 6 1947

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Balto National

Location

Frederick Road

18. Funeral director

Leo G. Cook

Address

1401-03 N Patterson Park Ave

19.

Dec 5 1947A.W. Hedrich

(Date rec'd by registrar)

Registrar

3.(b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 3/47 at 6:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Coronary accident

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm McCarroll M.D.
Deputy Medical Examiner
Address Balto. Co. Dundalk Md 21222

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10870

35-

1. PLACE OF DEATH:

County BaltimoreCity or town Freeland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 68 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Freeland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Elsie May Bohlayer.

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife John A. Bohlayer6. (c) If alive, give age 73 years7. Birth date of deceased (mo., day, yr.) May 24, 18798. AGE: Years 68 Months 6 Days 10 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore Co., Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name Wm. Stenbaker13. Birthplace Md.14. Maiden name Catherine Tracey15. Birthplace Freeland, Md.16. Informant John A. BohlayerAddress Freeland, Md.17. Burial Date thereof Dec. 7, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. ZionLocation Freeland, Md.18. Funeral director Joseph HarkensleyAddress New Freedom Pa.19. Dec 5 1947 Charles L. S. S. S.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1947 2:00 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Dec. 4 1947and that I last saw him alive on Dec. 4 1947Immediate cause of death Cerebral Thrombosis

Due to _____

Due to _____

Other conditions Arterio-sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

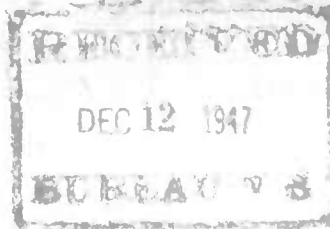
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A. M. France M. D. or other _____Address Parlatus, Md. Date signed 12/5/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10871

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town near Bayton and
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md- County BaltimoreCity or town near Bayton
(If outside city or town limits, write RURAL and give nearest town)Street No. Bellona av
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Benne H. Boone6. (c) If alive, give age ✓ years

7. Birth date of

deceased (mo., day, yr.)

Aug-25-1868

8. AGE:

Years

79

Months

3

Days

8

If less than one day

hrs.min.

9. Birthplace

Baltimore, Md
(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

12. Name

Wm. Marshall Boone

13. Birthplace

Baltimore

14. Maiden name

Sarah P. Kennedy

15. Birthplace

Baltimore16. Informant Mr. Gordon Boone (son)Address Bellona av.17. Burial Date thereof 12-5-47
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Lincoln ParkLocation Baltimore18. Funeral director Stewart M. MunnAddress 10847 York - Baltimore19. 12/4 19 47 A. W. Ketruck
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2, 19 47, at 10:00 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15, 19 47, to Dec 1, 19 47.and that I last saw him alive on Dec 1, 19 47.

Immediate cause of death

Coronary OcclusionDue to Cardio-vascular diseaseDue to other

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos Green M.D.Address Gawson - 4 - md Date signed 12/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10872

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
County <u>Baltimore</u>		(For newborn infants give residence of mother)	
City or town <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town)		State <u>Maryland</u> County _____	
How long in above place of death? <u>2 years, 2 months, 18 days</u>		City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town)	
Hospital, institution, or street address where death occurred: <u>Spring Grove State Hospital</u>		Street No. <u>1220 Linden Avenue</u> (If rural, give LOCATION)	
How long in hospital or institution? <u>2 years, 2 months, 18 days</u>		2.(a) If veteran, name war _____	

3. (a) FULL NAME <u>Agnes Borjas or Agnes H. Borjes</u>	3. (b) Social Security Number _____
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4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widowed</u>
6. (b) Name of husband or wife <u>Richard Frederick Borjas</u> (deceased)		
6. (c) If alive, give age _____ years		
7. Birth date of deceased (mo., day, yr.) <u>November 19, 1875</u>		
8. AGE: Years <u>72</u>	Months <u>--</u>	Days <u>23</u>hrs.min.

9. Birthplace <u>England</u> (Town, county, and state)
10. Usual occupation <u>Housewife</u>
11. Industry or business <u>Home</u>
MOTHER FATHER
12. Name <u>James Child</u>
13. Birthplace <u>England</u>
14. Maiden name <u>Jane Hardy</u>
15. Birthplace <u>England</u>

16. Informant <u>Hospital records</u> Address <u>Catonsville, 28, Md.</u>
17. <u>Burial</u> Date thereof <u>12/16/47</u> (Burial, cremation, or removal. Which?) (month) (day) (year) <u>Western Cem.</u> Cemetery or crematory Location <u>Balto., Md.</u>
18. Funeral director <u>WM. J. TICKNER & SONS</u> Address <u>Balto., Md.</u>
19. <u>Dec. 16, 47</u> <u>A. W. Hedrich</u> (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 19 47 at 2:35 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 25 19 45 to December 12 19 47and that I last saw h. _____ alive on December 12, 1947 19 _____Immediate cause of death Arteriosclerotic heart disease - coronary sclerosis DURATION IndefiniteDue to Generalized arteriosclerosis " "Due to Hypertensive cardio-vascular " "Carcinoma of the cervix IndefiniteOther conditions Carcinoma of the rectum - less thannonobstructive 2 years

(Include pregnancy within 8 months of death)

Major findings of operations Radium implantationDate of op. 5/26/47Autopsy results None held

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M. D. M. D. or otherAddress Catonsville, 28, Md. Date signed 12/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 108734

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 34 days
 Hospital, institution, or street address where death occurred:
V.A.H. Fort Howard, Md.
 How long in hospital or institution? 34 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2412 Madison Ave.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW-I

3. (a) FULL NAME

ROBERT H. BOULDIN

3. (b) Social Security Number
220-01-8494
220-01-34972

4. Sex Male 5. Color or race Colored 8. (a) Single, married, widowed, or divorced Married-Separated

6. (b) Name of husband or wife Beatrice Bouldin7. Birth date of deceased (mo., day, yr.) July 27, 18906. (c) If alive, give age 49 years

8. AGE: Years 57 Months 4 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business _____

12. Name William Bouldin13. Birthplace Baltimore, Md.14. Maiden name Mary Dorsey15. Birthplace Baltimore, Md.16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Md.17. Burial Date thereof Dec. 5, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Md.18. Funeral director Robert YoungAddress 1216 N. Caroline St. Balto. Md.

19. Dec. 5 19 47 A.W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 19 47 at 8:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 28 19 47 to December 1 19 47and that I last saw him alive on December 1 19 47

Immediate cause of death Rhabdomyosarcoma of left lung, Pleura, Gall Bladder and Jejunum
 Due to Unknown
 Due to _____
 Other conditions Pneumonectomy, left
 (Include pregnancy within 8 months of death)

Major findings of operations Pneumonectomy, leftDate of op June 19, 1947Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE JOSEPH H. SAUNDERS, M.D. M. D. or otherAddress V.A.H. FORT HOWARD, MD. Date signed 12/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10868

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Baths Co.
 City or town Bradshaw
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Bradshaw
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name was Spanish American

3. (a) FULL NAME

William F. Bradley Bradley

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 28 - 1861 6. (c) If alive, give age _____ years

8. AGE: Years 86 Months 4 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Ind.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Patrick Bradley
 13. Birthplace Ireland
 14. Maiden name Ann S. Ryan
 15. Birthplace Ireland

16. Informant Blanca Miller
 Address Bradshaw Ind.

17. Burial Date thereof Dec. 26 - 47
 (Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory St. Stephens Comm.

Location Bradshaw Ind.

18. Funeral director Clarence E. Arthur

Address Fork Ind.

19. Dec. 25 19 47 C. E. Arthur
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 December 1947 at 1:30 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945 to Dec 22 1947
 and that I last saw him alive on 23 Dec 1947

Immediate cause of death arteriosclerotic Cardiovascular disease
 DURATION 2 yrs
 Due to Cardiac decompensation 2 mo

Due to _____
 Other conditions senility

(Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE S. Edwin Muller
2m Read St Balto M. D.
 Address _____ Date signed 22 Dec 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town..... Pikesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County.....City or town..... Pikesville
(If outside city or town limits, write RURAL and give nearest town)Street No..... Woodholme Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

READA L. BRAGER.

3. (b) Social Security Number

4. Sex.....

Female

5. Color or race.....

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife..... A. Stanley Brager.

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1894

8. AGE: Years..... Months..... Days..... If less than one day

5311

..... hrs. min.

9. Birthplace..... Baltimore, Md.
(Town, county, and state)10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Isaac Leopold.13. Birthplace..... Balto. Md.14. Maiden name..... Rose Heineman.15. Birthplace..... Balto. Md.16. Informant..... Mr. A. Stanley Brager.Address..... Woodholme Ave. Pikesville.17. Burial..... 12.26.47.
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Baltimore HebrewLocation..... Balto. Md.18. Funeral director..... David Sanderson, SonAddress..... 1902 Eutaw Place. Balto. Md.19. (Date rec'd by registrar)..... 19.....
Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 24th. 19..... 47 at..... A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 19..... 45 to..... date
and that I last saw..... 17/22/47..... 19.....

Immediate cause of death.....

Amiotrophic Lateral
Sclerosis

DURATION

5 year

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... injured at work?

23. SIGNATURE..... Alan Bernies M.D.Address..... 1109 N. Calvert St. Date signed..... 12/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10875

Reg. Dist. No. 39

1. PLACE OF DEATH:

County Baltimore
 City or town Monkton (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 years
 Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Monkton P.O. (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Carbett St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles Brauer

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Estelle (nee Koch)

7. Birth date of

deceased (mo., day, yr.)

Nov. 11, 1879

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

68-28

hrs.

min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

FATHER

12. Name

David Brauer

13. Birthplace

Germany

MOTHER

14. Maiden name

Catherine Hook

15. Birthplace

Baltimore, Md.

16. Informant

Address

Miss Loris Virginia BrauerMonkton, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

Dec. 12, 1947
(month) (day) (year)

Cemetery or crematory

Parkwood Balto, Md.

Location

Parfville, Balto., Md.

19. Funeral director

Address

Samuel M. DevolisSparks, Md.

19.

(Date rec'd by registrar)

Dec. 11, 1947Anna Price

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1947, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 7, 1947 to Dec. 9, 1947and that I last saw him alive on Dec. 9, 1947

Immediate cause of death

Coronary Thrombosis

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. M. France

M. D. or other

Address

Parkton, Md.Date signed 12/10/47

RECEIVED
DEC 13 1947
6 4 2 5 1 1 3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10876

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County BaltoCity or town Bradshear
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

80

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

19

at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h..... alive on

19

Immediate cause of death

DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

23. SIGNATURE

Address

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940

10837

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

204 Shady Hook Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 204 Shady Hook Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charles J. Bruchey

3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Editha Bruchey

7. Birth date of

deceased (mo., day, yr.)

May 29 1902

5. (c) If alive, give age years

8. AGE:

Years 45 Months 6

Day

If less than one day

28

hrs.

min.

9. Birthplace

md
(Town, county, and state)

10. Usual occupation

Pay roll clerk

11. Industry or business

John H. Bruchey

MOTHER

FATHER

12. Name

John H. Bruchey

13. Birthplace

md

14. Maiden name

Carolyn ?

15. Birthplace

md

16. Informant

Address

Edith M. Bruchey
204 Shady Hook Rd

17. (Burial, cremation, or removal. Which?)

Date thereof 12-24-47
(month) (day) (year)

Cemetery or crematory

St. Louis Park

Location

Baltimore

18. Funeral director

Address

George A. Farley
Catonsville, Md.19. 12/24 19 47
(Date rec'd by registrar)G. W. Hedrich
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 19 47 at 2-35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

10.....

19.....

and that I last saw him..... alive on.....

19.....

Immediate cause of death

Coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Geo. M. KiefferEditha Bruchey
M. D. or otherAddress 1010 Leaden Hall Date signed 12-22-47

Set from
K. H. H. H.
H. H. H. H.
H. H. H. H.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10878

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 Days

Hospital, institution, or street address where death occurred:

Vets. A.M. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 18 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 103 N. Carey St.
(If rural, give LOCATION)2.(a) If veteran, name war WW-2

3. (a) FULL NAME

THOMAS F. BYRNES

3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single6.(b) Name of husband or wife Single7. Birth date of deceased (mo., day, yr.) November 7, 19058. AGE: Year 42 Months 1 Days 14 If less than one day hrs. min.8. Birthplace Maryland
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Thomas Byrnes13. Birthplace Maryland14. Maiden name Rose Muldoon15. Birthplace Maryland18. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Md.17. Burial Date thereof 12/24/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Howard Blight Funeral HomeAddress 4914 Belair Rd., Balto., Md.19. 12/23 19 47 A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 19 47 3:10 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 3, 19 47 to December 21, 19 47and that I last saw him alive on December 21, 19 47

Immediate cause of death

Pulmonary Tuberculosis, bilateralAdvanced, Active.

Due to

Due to

Other conditions Lateral sinus thrombosisCause, Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P.O. AndersonP.O. ANDERSON, M. D. M. D. or otherAddress V.A.H. Ft. Howard, Md. Date signed 12-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10879

Reg. Diat. No. 33

1. PLACE OF DEATH:

County Balto.
 City or town Reisterstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.
 City or town Reisterstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 36 Main St.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Lewis Calvin Caltrider

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mary Elizabeth Caltrider
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 8, 1868
 8. AGE: Years 79 Months 7 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Carroll Co.
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name George Caltrider13. Birthplace Carroll Co.14. Maiden name Jane Wooden15. Birthplace Carroll Co.16. Informant Mary E. CaltriderAddress Reisterstown, Md.17. Burial Date thereof Dec. 18, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. PaulLocation Arcadia Balto. Co.18. Funeral director J. F. Eline & SonsAddress Reisterstown, Md.19. Dec-18-1947 Mary B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 19 47 at 10:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 _____, to 10-15- 19 47and that I last saw him alive on 10-15-47 19 _____Immediate cause of death Coronary Artery Disease DURATION 3 mo.Due to Hypertensive & V. Disease 7 mos

Due to _____

Other conditions Carcinoma of Prostate 5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

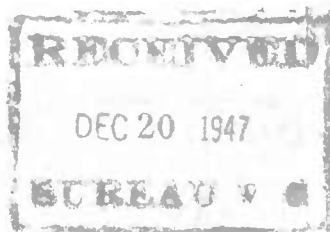
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? Home (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE D. A. Caples M.D. M. D. or otherAddress Reisterstown, Md. Date signed 12-17-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH

County Baltimore
City or town Hernwood
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Samuel Cannon

3. (b) Social Security Number

743-13-96714. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife May Adelle Cannon7. Birth date of deceased (mo., day, yr.) May 2, 1868 6. (c) If alive, give age _____ years8. AGE: Years 79 Months 7 Days 10 If less than one day _____ hrs. _____ min.9. Birthplace Dorchester Co. Md.
(Town, county, and state)10. Usual occupation Retired - Farmer11. Industry or business Heavy Ship12. Name Charles Cannon13. Birthplace Dorchester Co. Md.14. Maiden name Edith Piper15. Birthplace Dorchester Co. Md.16. Informant Mrs. Edith PiperAddress Hernwood Rd. - Baltimore Co. Md.17. Burial Date thereof Dec. 15, 1947
(Burial, cremation, or removal, Which) (month) (day) (year)Cemetery or crematory Woodlawn CemeteryLocation Woodlawn Baltimore Co. Md.18. Funeral director B. Ellis LammiganAddress 4510 Liberty Heights Ave.19. 12/13/47 1947 Tom E. Martin
(Date rec'd by registrar) (Year) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md. County BaltimoreCity or town Hernwood
(If outside city or town limits, write RURAL and give nearest town)Street No. Hernwood Road
(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1947 at 10 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 45 to 12/12/1947and that I last saw him alive on Dec. 12, 1947

Immediate cause of death _____ DURATION _____

Cardiovascular Dis.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

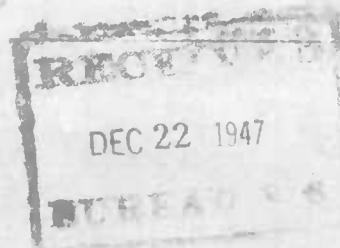
Means of injury _____ Injured at work? _____

23. SIGNATURE Tom E. Martin M. D. or other _____Randalltown Date signed 12/13/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10881

Reg. Dist. No. 92

1. PLACE OF DEATH:

County Balto.
 City or town Lutherville R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 yr.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Balto.
 City or town Lutherville R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Greenspring Ave. Chestnut Ridge
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Katherine Christine Caple

3. (b) Social Security Number

4. Sex Female 5. Color or race hite 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Charles C. Caple
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) March 14, 1868
 8. AGE: Years 79 Months 9 Days 17 If less than one day _____ hrs. _____ min.

9. Birthplace Carroll Co.
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business _____
 12. Name Lewis Shipley
 13. Birthplace Carroll Co.
 14. Maiden name Christine Undersock
 15. Birthplace Germany

16. Informant Mrs. Robert Brown
 Address Lutherville, Md.
 17. Burial Jan. 2, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Sandy Mount
 Location Carroll Co.
 18. Funeral director J.F. Eline & Sons
 Address Reisterstown, Md.
 19. 1-2-48 Dr. E.E. Nichols
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1947 at 2 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 to Dec 31 1947
 and that I last saw him/her alive on Dec 30 1947
 Immediate cause of death Chronic Myocarditis ?
arterio sclerosis ?
 Due to _____
 Due to _____
 Other conditions Senility ?
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE E.E. Nichols M.D. or other _____
Pikesville 8-Md Address _____ Date signed 1-2-48

RECEIVED
JAN 3 1948
BUREAU

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF MARYLAND
BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 8882

1. PLACE OF DEATH: CARNEY Balto.
 (a) Baltimore City, Maryland
 (b) Street address: Harford Rd near Summit Ave
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MD (b) County
 (c) City or town BALTO. CARNEY
 (If outside city or town limit, write RURAL and give town)
 (d) Street No. Harford Rd. near Summit Ave
 (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAME

Birdie May Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife William W. Carroll

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14th 1882

8. AGE: Years 65 Months 2 Days 5 If less than one day
 hr. min.

9. Birthplace Balto. Md.
 (Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name Thomas J. Glauville

13. Birthplace Balto. Md.

14. Maiden Name Kate Parks

15. Birthplace Balto. Md.

16 (a) Informant Arthur C. Carroll

(b) Address Harford Rd near Summit Ave

17 (a) Burial (b) Date thereof 12/23/47
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park
 Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) 12/20/47 (b) A. W. Hedrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19th 1947 at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to 12/19 1947 and that I last saw her alive on 12/19 1947

Immediate cause of death Myocardial Infarction Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. E. Hedrich M. D.

Address 3723 Harford Rd Date signed 12/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10883

Reg. Dist. No. 41

1. PLACE OF DEATH

County... Balto Co.
 City or town... 1816 N. Paint Pl. Balto.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Balto
 City or town... 1816 N. Paint Pl.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Dundalk 22nd
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Hattie Carter

3. (b) Social Security Number

4. Sex F 5. Color or race Col 6.(a) Single, married, widowed, or divorced widow

6.(b) Name of husband or wife

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) unknown

8. AGE: 63 Years Months Days If less than one day
 hrs. mto.

9. Birthplace Smithtown, West Va.
 (Town, county, and state)

10. Usual occupation Homemaker

11. Industry or business Home

12. Name George Mackey

13. Birthplace West Virginia

14. Maiden name Ella Collins

15. Birthplace unknown

16. Informant Elizabeth Rogers

Address 1816 North Pl. Rd. Dundalk

17. Buried Date thereof Dec 11-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Hope Cem.

Location Martinsburg, West Va.

18. Funeral director Elroy D. Wilson

Address 1000 Brantley Ave

19. 12/14/47 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8th 1947 at 4:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1st 1947 to Dec 8th 1947 and that I last saw him alive on Dec 7th 1947

Immediate cause of death Myocardial Insufficiency DURATION unknown

Due to

Due to Cardiac asthma unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Thomas M.D.

Address Jennings St. Md. Date signed 12/8/47

CERTIFICATE OF DEATH

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DEC 18 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10884

Reg. Dist. No. 38

1. PLACE OF DEATH: County <u>Baltimore</u> City or town <u>Towson Furnace Branch Providence Rd</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Sudden</u> Hospital, institution, or street address where death occurred: <u>Furnace Branch Providence Rd</u> How long in hospital or institution?		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Baltimore</u> City or town <u>Towson</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Dulaney Valley Road (Hampton Farm)</u> (If rural, give LOCATION) <u>R.F.D. #8</u> 2.(a) If veteran, name war	
3. (a) FULL NAME <u>John Ruben Carter</u>		3. (b) Social Security Number <u>217-14-9154</u>	
4. Sex <u>Male</u>		5. Color of face <u>White</u>	
6. (a) Single, married, widowed, or divorced <u>Married</u>		6. (b) Name of husband or wife <u>Jane R. Carter</u>	
7. Birth date of deceased (mo., day, yr.) <u>April 16, 1884</u>		6. (c) If alive, give age <u>63</u> years	
8. AGE: Years <u>63</u> Months <u>8</u> Days <u>13</u> hrs. min.		20. DATE OF DEATH <u>December 29</u> 19 <u>47</u> at <u>1045 A.</u> M.	
9. Birthplace <u>Blountsville, Tenn.</u> (Town, county, and state)		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 <u>19</u> to <u>19</u>	
10. Usual occupation <u>Laborer</u>		and that I last saw him <u>alive</u> on <u>December 23</u> 19 <u>47</u>	
11. Industry or business <u>County Highways Dept.</u>		Immediate cause of death <u>Heart disease, vascular coronary with occlusion Sudden</u> DURATION <u>Sudden</u>	
12. Name <u>James Carter</u>		Due to	
13. Birthplace <u>Tenn.</u>		Due to	
14. Maiden name <u>Nannie E. McLaughlin</u>		Other conditions	
15. Birthplace <u>Tenn.</u>		(Include pregnancy within 3 months of death)	
16. Informant <u>Robert Carter</u>		Major findings of operations	
Address <u>Towson, Md. R.F.D. #8.</u>		Date of op.	
17. Burial <u>Dec 31, 1947</u> (Burial, cremation, or removal, Which?) (month) (day) (year)		Autopsy results	
Cemetery or crematory <u>May's Chapel Cemetery</u>		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
Location <u>Lutherville, Balto. Co., Md.</u>		22. VIOLENCE: A death was due to external causes, fill in the following:	
18. Funeral director <u>John Burns & Sons</u>		Accident, suicide, or homicide	
Address <u>Towson, Maryland</u>		Where did injury occur? (City or town) (County) (State)	
19. Dec 31, 19 47 (Date rec'd by registrar)		Injured at home, farm, industry, public place (where?)	
Registrar		Means of injury Injured at work?	
23. SIGNATURE <u>Rollin L. Hudson MD. DME</u>		Address <u>Towson Md</u> Date signed <u>12/29/47</u>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10885

Reg. Dist. No. 34

1. PLACE OF DEATH County..... <u>Baltimore</u> City or town..... <u>Pleasant Grove</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <u>20 years</u> Hospital, institution, or street address where death occurred:..... How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Baltimore</u> City or town..... <u>Pleasant Grove</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... (If rural, give LOCATION) 2. (a) If veteran, name war.....			
3. (a) FULL NAME <u>Howard Chilcoat</u>				3. (b) Social Security Number			
4. Sex <u>M</u>		5. Color or race <u>W</u>		6. (a) Single, married, widowed, or divorced <u>M.</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <u>Rose Chilcoat</u>				20. DATE OF DEATH <u>Dec 2</u> 19 <u>47</u> .. at <u>5 A</u> .. M			
7. Birth date of deceased (mo., day, yr.) <u>June 4 - 1866</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>11-26</u> 19 <u>45</u> .. to..... <u>12-2</u> 19 <u>47</u> .. and that I last saw him... alive on..... <u>Dec 1</u> 19 <u>47</u> ..			
8. AGE: Years..... <u>81</u> Months..... <u>5</u> Days..... <u>28</u> If less than one day..... hrs. min.		6. (c) If alive, give age <u>81</u> years		Immediate cause of death <u>arteriosclerosis</u>			
9. Birthplace <u>Maryland</u> (Town, county, and state)				DURATION <u>5 yrs Est.</u>			
10. Usual occupation <u>Retired Merchant</u>				Due to			
11. Industry or business				Due to			
12. Name <u>Unknown</u>				Other conditions			
13. Birthplace <u>Unknown</u>				(Include pregnancy within 8 months of death)			
14. Maiden name <u>Unknown</u>				Major findings of operations <u>None.</u> Date of op.			
15. Birthplace <u>Unknown</u>				Autopsy results			
16. Informant <u>Mrs Howard Chilcoat</u> Address..... <u>Reisterstown Md</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. Burial (Burial, cremation, or removal, Which?) Date thereof..... <u>Dec 5/47</u> (month) (day) (year) Cemetery or crematory..... <u>Pleasant Grove</u> Location..... <u>Baldco Md</u> <u>Edw. E. Tipton</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....			
18. Funeral director <u>Edw. E. Tipton</u> Address..... <u>Hamptstead Md</u>				23. SIGNATURE <u>D. D. Copley, M.D.</u> M. D. or other Address..... <u>Reisterstown Md</u> Date signed <u>12-2-47</u>			
19. 12-3 (Date rec'd by registrar)				19. 47 <u>Cyril E. Tipton</u> Registrar			

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DEC 5 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Relay
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 14 days
 Hospital, institution, or street address where death occurred:
Relay, Baltimore
 How long in hospital or institution?..... 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore
 City or town..... Relay, Md. 5509 Baltimore Road
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 5509 Baltimore Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... None

3. (a) FULL NAME

Samuel Martin Clark

3. (b) Social Security Number

None

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Widowed
 6.(b) Name of husband or wife..... Mary Rebecca Clark
July 13, 1887 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)
 8. AGE: Years..... 66 Months..... 5 Days..... 14 If less than one day..... hrs. min.

9. Birthplace..... Brown, Cumberland County, Ind.
 (Town, county, and state)
 10. Usual occupation..... Chauffeur
 11. Industry or business..... State of Md.

12. Name..... Samuel J. Clark
 13. Birthplace..... Maryland
 14. Maiden name..... Sarah Johnson
 15. Birthplace..... Maryland

16. Informant..... Mrs. Emma Kind, daughter
 Address..... Relay, Md.
 17. Burial..... Date thereof..... 12/30/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery..... Friendship Cem. A. A. Co.
 Location..... Friendship, Md.

18. Funeral director..... WM. J. TICKNER & SONS INC.
 Address..... North & Pa. Aves. Balto. 17, Md.

19. Dec 29 47 A. W. Hedmon
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec 27 E 19. 47, at 10:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 13 E 19. 47, to Dec 27 E 19. 47
 and that I last saw him alive on Dec 27 E 19. 47

Immediate cause of death..... Arteriosclerotic heart disease DURATION..... Several weeks

Due to..... Arteriosclerotic heart disease DURATION..... Several years

Due to.....

Other conditions..... Anginal pectoris, etc DURATION..... Unknown
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE..... Ernie P. Hedmon M.D.
 Address..... Relay, Md. Date signed..... 12/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

10887

1. PLACE OF DEATH:

County BALTO.
 City or town CATONSVILLE
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

OPITZ NURSING HOME

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County BALTO.
 City or town BALTIMORE
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4928 DENMORE AVE
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

CHARLES H. CLAYVILLE

3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Maude F. Clayville

7. Birth date of deceased (mo., day, yr.)

Sept. 13, 1868

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

79

3

3

hrs.

min.

9. Birthplace

Snow Hill, Md.

(Town, county, and state)

10. Usual occupation

Agent

11. Industry or business

P. R. R.

MOTHER FATHER

12. Name

Henry Clayville

13. Birthplace

-

14. Maiden name

-

15. Birthplace

-

16. Informant

Mr. Charles E. Clayville

Address

4930 Denmore Ave.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

12/18/47

(month) (day) (year)

Cemetery or crematory

Church Hill Cem.
Church Hill, Md.

Location

WM. J. TICKNER & SONS

18. Funeral director

Balto., Md.

Address

19.

Dec 17, 47
(Date rec'd by registrar)A. W. Hadriel
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 19 47 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 11 19 47 to Dec 16 19 47and that I last saw him alive on Dec 15 19 47

Immediate cause of death

Cerebral Hemorrhage

DURATION

3 days

Due to

Generalized Arterio Sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Catonsville Date signed 12/16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10888

Reg. Dist. No. 43

1. PLACE OF DEATH:

County Baltimore
 City or town Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Fullerton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Belair Rd. & Louise Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

ELLEN COOPER

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widow
 6.(b) Name of husband or wife Wm. J. Cooper
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Oct. 5th, 1859
 8. AGE: Years 88 Months 1 Days 29 It less than one day _____ hrs. _____ min.

9. Birthplace England
 (Town, county, and state)
 10. Usual occupation at home
 11. Industry or business _____

FATHER 12. Name William Woolliscroft
 13. Birthplace England
 MOTHER 14. Maiden name Mary A. Price
 15. Birthplace England

16. Informant Mrs. John I. Smith
 Address Belair Rd. & Louise Ave.

17. burial Date thereof 12/8/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Oak Lawn
 Location 7225 Eastern Ave.

18. Funeral director Lassaka Funeral Home
 Address 7401 Belair Road

19. Dec 5 19 47 Ans. G. J. Rufin
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4th, 19 47 at 6:45p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 29 19 47 to Dec. 4 19 47
 and that I last saw him/her alive on Dec. 4 19 47

Immediate cause of death Cerebral thrombosis
 Due to arterio sclerosis, limited, generalized
 Due to _____

Other conditions _____
 (Include pregnancy within 8 months of death)
 Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE William J. Smith
 Address 6222 Belair Rd, Balt. 6 M. D. or other Dec 5, 1947
 Date signed

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DEC 10 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 1860
 10889
 Reg. Dist. No. 30

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 years, 9 months, 17 days
 Hospital, institution, or street address where death occurred:
 Spring Grove State Hospital
 How long in hospital or institution? 13 years, 9 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland..... County..... Carroll
 City or town..... Sykesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

Edwin Criswell

3. (b) Social Security Number

4. Sex..... male
 5. Color or race..... white
 6. (a) Single, married, widowed, or divorced..... divorced

6. (b) Name of husband or wife..... ?
 6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) May 2, 1873

8. AGE: Years Months Days If less than one day
 74 7 20 hrs. min.

9. Birthplace..... Maryland
 (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... Miscellaneous

12. Name..... Edwin Criswell

13. Birthplace..... Maryland

14. Maiden name..... Cordelia Conaway

15. Birthplace..... Maryland

16. Informant..... Hospital records

Address..... Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal, which?) Date thereof 12-24-47 (month) (day) (year)

Cemetery or crematory..... Green

Location..... Winfield, Carroll Co. Md

18. Funeral director..... G. M. Watts

Address..... Winfield Md

19. 12/27 19 47 A. W. Hedwich Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 22 1947 at 7:10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....
 and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Arterio-sclerotic heart disease

Due to.....

fractured left femur

Due to.....

Accident

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of death 12-24-47

Where did injury occur? Catonsville, Baltimore, Md (City or town) (County) (State)

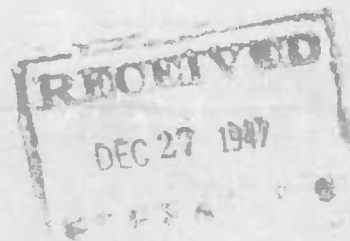
Injured at home, farm, industry, public place (where?) Hospital

Means of injury..... Fell out of his bed Injured at work?

Signature..... G. M. Watts

23. SIGNATURE..... M. D. or other

Address..... 1010 Seaboard Ave Date signed 12-22-47



COPY SENT TO ^{CHO}~~LOCAL~~ REGISTRAR No. _____ DATE 12/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 39

10891

1. PLACE OF DEATH:

County BaltimoreCity or town Monkton (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Monkton (Rural)
(If outside city or town limits, write RURAL and give nearest town)Street No. Old York Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Francesina Edwards Cury

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Wm. D. Cury7. Birth date of deceased (mo., day, yr.) Nov. 18 1858 6. (c) If alive, give age 85 years8. AGE: Years 89 Months - Days 17 If less than one day hrs. min.9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Richard Edwards13. Birthplace Balto., Md.14. Maiden name Fannie Ross15. Birthplace Balto., Md.16. Informant Mrs. John PattersonAddress Monkton, Md.17. Funeral Date thereof Dec. 8, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Landon ParkLocation Balto., Md.18. Funeral director Sandy M. BurchAddress Sparks, Md.19. Dec. 5, 1947 Anna Price
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 December 1947 at 3 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 November 1947 to 5 December 1947
and that I last saw h. 85 alive on 3 December 1947Immediate cause of death cardiac failure DURATION 2 wksDue to Arterio sclerosis

Due to

Other conditions Hypostatic pneumonia 1 wk

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Kees M.D. M. D. or otherAddress Cockeysoville, Md. Date signed 5 Dec 47

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10892

1. PLACE OF DEATH:

County Baltimore

City or town Towson 4, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since June 24, 1947

Hospital, institution, or street address where death occurred:

Towson 4, Maryland

How long in hospital or institution? Since June 24, 1947

3. (a) FULL NAME

Callie Elizabeth Lane

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

B. (a) Single, married, widowed, or divorced

Divorced

B. (b) Name of husband or wife

John B Lane

7. Birth date of deceased (mo., day, yr.)

February 9, 1917

B. (c) If alive, give age

35 years

8. AGE:

Years 39

Months 10

Days

If less than one day

hrs. min.

9. Birthplace

Stuart Va

(Town, county, and state)

10. Usual occupation

Cashier

11. Industry or business

in a restaurant

FATHER

12. Name

James E Justice

13. Birthplace

Patrick County, Va

MOTHER

14. Maiden name

Delia Justice

15. Birthplace

Patrick County, Va

Personal history - Hospital Records

16. Informant

Eudowood Sanatorium, Towson 4, Md.

17. Date of death

June 26, 1947

18. Date of death

June 26, 1947

19. (Date rec'd by registrar)

June 26, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore 18

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1008 Bonaparte Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1947 5:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 24, 1947 to December 23, 1947

and that I last saw him alive on December 22, 1947

Immediate cause of death

Pulmonary tuberculosis

Due to

about June 1, 1947

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mens of injury Injured at work?

23. SIGNATURE W A Bridges

M. D. or other

Address Towson 4, Md.

Date signed 12-22-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 Reg. Dist. No. 1089244

1. PLACE OF DEATH: County <u>Baltimore</u> City or town <u>Fort Howard</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>126 days</u> Hospital, institution, or street address where death occurred: <u>V. A. H. Fort Howard, Maryland</u> How long in hospital or institution? <u>126 days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County _____ City or town <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>3905 Greenmount Avenue</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>VV I</u>	
--	--	--	--

3. (a) FULL NAME <u>FREDERICK S. DEEDS</u>	3. (b) Social Security Number <u>214-09-6396</u>
--	--

4. Sex <u>male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>married</u>
6. (b) Name of husband or wife <u>Christine Deeds</u>		
7. Birth date of deceased (mo., day, yr.) <u>February 15, 1893</u>		
6. (c) If alive, give age <u>42</u> years		
8. AGE: Years <u>54</u>	Months <u>10</u>	Days <u>2</u> If less than one dayhrs.min.
9. Birthplace <u>Maryland</u> (Town, county, and state)		
10. Usual occupation <u>Unemployed</u>		
11. Industry or business		
12. Name <u>Bruce Deeds</u>		
13. Birthplace <u>Maryland</u>		
14. Maiden name <u>Blanche Grush</u>		
15. Birthplace <u>Maryland</u>		

16. Informant <u>Clinical Records, Vets. Adm. Hosp.</u>	
Address <u>Fort Howard, Maryland</u>	
17. <u>Burial</u>	Date thereof <u>Dec. 17 47</u> (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory <u>Antietam National Cemetery</u>	
Location <u>Sharpsburg, Maryland</u>	
18. Funeral director <u>Howard N. Sligh Jr.</u>	
Address <u>4914 Belair Road Balto., Md.</u>	
19. <u>Dec 17 - 47</u> <u>Sawon T. Harber</u> (Date rec'd by registrar) Registrar	

MEDICAL CERTIFICATION 20. DATE OF DEATH <u>December 17</u> 19 <u>47</u> at <u>8:15a</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>August 13</u> 19 <u>47</u> , to <u>December 17</u> 19 <u>47</u> and that I last saw him alive on <u>December 17</u> 19 <u>47</u> Immediate cause of death <u>Massive Pulmonary Emboli</u> DURATION <u>Bilateral</u> <u>Sudden</u> Due to <u>Thrombosis Iliac Veins</u> <u>Unknown</u> Due to _____ Other conditions <u>Essential Hypertension</u> <u>10 yrs plus</u> <u>Hemorrhage in Arteriosclerotic</u> <u>Plaque Coronary Artery</u> <u>10 da. plus</u> (Include pregnancy within 3 months of death) Major findings of operations _____ Date of op. _____ Autopsy results <u>Substantiated above</u> PHYSICIAN: Please underline the cause in which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) (County) (State) Injured at home, farm, industry, public place (where?) _____ Means of injury <u>W.H. Heath</u> Injured at work? <u>O.D. Res. Surg</u> 23. SIGNATURE <u>W.H. HEATH, M.D.</u> M. D. or other <u>VAH, Fort Howard, Md.</u> Address _____ Date signed _____	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10894

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 months

Hospital, institution, or street address where death occurred:

1500 Frederick Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Catonville
(If outside city or town limits, write RURAL and give nearest town)Street No. 1500 Frederick Road

(If rural, give LOCATION)

2.(a) If veteran, name war World War 1 & World War 2

3. (a) FULL NAME

Henry Houck Dill

3. (b) Social Security Number

578-22-7498

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Divorced6.(b) Name of husband or wife Esther R.

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1897

8. AGE: Years Months Days If less than one day

50 1 20 _____ hrs. _____ min.9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Salesman11. Industry or business Lumber Co.12. Name Henry H. Dill13. Birthplace Frederick Md.14. Maiden name Marie Dubant15. Birthplace Philadelphia, Penna.16. Informant Mr. W. C. RettAddress 1500 Frederick Rd. Catonsville17. Burial Date thereof Dec. 17, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Landon ParkLocation Frederick Ave. Balto. Md.16. Funeral director Easton SonsAddress 608 Frederick Ave. Catonsville19. 12/20 1947 A. W. Hedrich

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15, 1947 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 27, 1947 to Dec. 15, 1947and that I last saw him alive on Dec. 11, 1947

Immediate cause of death

Arterial SclerosisMyocarditisAngina Pectoris

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE S. Lloyd JohnsonAddress CatonvilleDate signed 12/15/47

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DEC 20 1967
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10895

1. PLACE OF DEATH: **Baltimore**
 County.....
 City or town..... **Fort Howard**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **8 days**
 Hospital, institution, or street address where death occurred:
Veterans Administration Hosp., Fort Howard
 How long in hospital or institution? **8 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... **Maryland** County.....
 City or town..... **Baltimore**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... **1515 East Eager Street**
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... **WW II**

3. (a) FULL NAME

EDMONDS, Joseph D.

3. (b) Social Security Number

Unknown

4. Sex **Male** 5. Color or race **Colored** 6. (a) Single, married, widowed, or divorced **Married - Separated**
 6. (b) Name of husband or wife..... **Selena Edmonds (Sep.)**
 7. Birth date of deceased (mo., day, yr.) **December 5, 1927** 6. (c) If alive, give age..... years
 8. AGE: Years **20** Months **0** Days **25** If less than one day
 hrs. min.

9. Birthplace..... **Baltimore, Maryland**
 (Town, county, and state)
 10. Usual occupation..... **Unemployed**
 11. Industry or business.....
 12. Name..... **Roger Edmonds**
 13. Birthplace..... **North Carolina**
 14. Maiden name..... **Menwila Johnson**
 15. Birthplace..... **North Carolina**

16. Informant..... **Clinical Records - Veterans**
 Address **Adm. Hospital, Fort Howard, Maryland**

17. **Burial** Date thereof **Jan 3 - 1947**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Mt. Cavalry Cemetery**
Baltimore, Maryland
 Location.....

18. Funeral director..... **Robert E. Williams**
 Address **1515 McElderry Street, Balto., Md.**

19. (Date rec'd by registrar) **1/2** **x8** **S.W. Hedrick**
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **December 30** 19 **47** at **11:05 P.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 22 19 **47** to **December 30** 19 **47**
 and that I last saw him alive on **December 30** 19 **47**

Immediate cause of death.....
Acute Glomerulonephritis DURATION **1 Month**

Due to.....

Due to.....

Other conditions..... **Syphilis, secondary** **6 Months**

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... **R. J. SCOTT, M. D.** M. D. or other

Address..... **V.A.H. FORT HOWARD, MD.** Date signed..... **12-31-47**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10896

Reg. Dist. No. 30

1. PLACE OF DEATH:

County BaltimoreCity or town Westowne
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hood Nursing Home -

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 117 Beaumont Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clara P. Ehlen

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife William B. Ehlen7. Birth date of deceased (mo., day, yr.) July 1, 1868

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

79411

hrs.

min.

9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Henry P. Smith13. Birthplace Md.14. Maiden name Emma Parlet15. Birthplace Md.16. Informant Mrs. Walter M. GieskeAddress 117 Beaumont Ave., Catonsville17. Burial Burial Date thereof 12-15-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid RidgeLocation Pikesville, Md.18. Funeral director J. Howard StrongAddress 3207 W. North Ave.19. 12/15 19 47 A. W. Hedrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 19 47 at 740 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20 19 47 to Dec 12 19 47 and that I last saw him alive on Dec 12 19 47Immediate cause of death Cor Myocarditis DURATION 1 yearDue to Generalized ArterioDue to Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

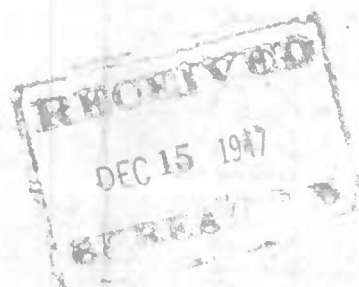
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Beaumont M. D. or otherAddress Catonsville Date signed 12/13



CNO
COPY SENT TO LOCAL REGISTRAR No. DATE 12/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Baltimore
City or town Glenarm
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
City or town Glenarm
(If outside city or town limits, write RURAL and give nearest town)
Street No. Long Green Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (a) FULL NAME

CATHERINE S. EICHOLTZ

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced single
6.(b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) Jan. 6th, 1877 6.(c) If alive, give age _____ years
8. AGE: Years 70 Months 11 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual occupation at home
11. Industry or business

12. Name Justus Eicholtz
13. Birthplace Germany
14. Maiden name Margaret M. Spring
15. Birthplace Germany

16. Informant Mrs. John W. Amrein
Address Long Green Rd., Glenarm

17. burial Date thereof 12/21/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Johns
Sweet Air, Md.
Location

18. Funeral director Lassahn Funeral Home
Address 7401 Belair Rd.

19. 12/19 1947
(Date reg'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18th 1947 at 7:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1942 to Dec. 18 1947
and that I last saw her alive on Dec. 18 1947.

Immediate cause of death Chronic myocarditis
Hypertension
DURATION 6 yrs.
6 yrs.

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. M. Bacon, M.D.
M. D. or other
Address 2810 Taylor Ave. Date signed 12/19/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

468

10899

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

216 Middle River Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Middle River
(If outside city or town limits, write RURAL and give nearest town)Street No. 216 Middle River Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robert G. Elliott

3. (b) Social Security Number

213-01-1938

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleColoredMarried6. (b) Name of husband or wife Caroline Elliott

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) January 4, 18948. AGE: Years Months Days It less than one day
53 11 22 hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Robert Elliott13. Birthplace Va.14. Maiden name Rebecca Plater15. Birthplace Baltimore, Md.18. Informant Mrs. Caroline ElliottAddress 216 Middle River Road17. Burial Date thereof 1-2-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Stephen's Cem.Location Essex, Middle River, Md.18. Funeral director Mrs. Frances A. HensleyAddress 578 W. Biddle St19. 12/21/47 d. w. J. H. H. H. H.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1947 at 8:10 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3, 1947 to December 7, 1947 and that I last saw him alive on December 9, 1947Immediate cause of death Carcinoma of Stomach

DURATION

about 6 mos

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jack Wexler, M.D.Address 805 Furlong Ave, Apt 20 Date signed 12/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 4419990**1. PLACE OF DEATH:**

- (a) Baltimore City, Maryland
 (b) Street address Bethlehem Steel-Sparrows Pt.
 (c) Hospital or institution:
 (d) Length of stay in hospital or inst. (yrs., mos., or days)
 (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Md (b) County Baltimore
 (c) City or town Dundalk-Turner Station
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. (If rural give location)
 (e) Citizen of foreign country? (Yes or No)
 If yes, name country

3 (a) FULL NAMEWILLIEEVANS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1888

8. AGE: Years

59

Months

Days

If less than one day

hr.min.

9. Birthplace

Un Known
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a)

(Burial, cremation, or removal)

(b) Date thereof

(month) (day) (year)

(c) Cemetery or crematory

Location

18 (a) Funeral director

(b) Address

19 (a)

(Date rec'd by registrar)

DM Registrar**MEDICAL CERTIFICATION**20. DATE OF DEATH December 10 1947, at 3:10 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATHCarbon monoxide Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:(a) Date of injury 12-11-47 at 1:30 P. M.(b) Where did injury occur? Sparrows Point, Md.(c) Did injury occur at home, on farm, industrial place, in public place? Bethlehem Steel While at work? Yes(d) Means of injury Fell up on scaffolding while loading brick.23. Signature Emil L. Ryan M.D.Date signed 12-11-47

Medical Examiner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1090142

1. PLACE OF DEATH:

County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1254 Linden Ave
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

William George Finkner

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Lillian E.
 6. (c) If alive, give age 66 years
 7. Birth date of deceased (mo., day, yr.) April 1st 1881
 8. AGE: Years 66 Months 8 Days 12 It less than one day - hrs. - min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation Dairyman - Retired
 11. Industry or business Cure Business
 12. Name John Finkner
 13. Birthplace Baltimore, Md.
 14. Maiden name Elizabeth Dinwiddie
 15. Birthplace Baltimore, Md.

16. Informant Mrs. Lillian E. Finkner
 Address 1254 Linden Ave. Baltimore
 17. Burial Date thereof Dec. 17-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory New Cathedral
 Location Baltimore, Md.
 18. Funeral director F. D. Shippert & Son
 Address 1900 Easton Place - 47
 19. 12-18-47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH December 13 1947 at 7:45 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1947 to Dec 13 1947
 and that I last saw him alive on Dec 6 1947

Immediate cause of death

Edema of Brain

DURATION

1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Edema of BrainDate of op. Feb 20, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Earl Pass, M.D.

M. D. or other

Address 4001 Wilkins Ave Date signed 12-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10902 47

1. PLACE OF DEATH:
 County Baltimore
 City or town Sparks
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Patuxent
 City or town 1809 95X
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Sparks
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Mary Emma Finney

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife John Finney

7. Birth date of deceased (mo., day, yr.) Oct 5-1869 8. (c) If alive, give age, 82 years

8. AGE: Years 78 Months 2 Days 3 If less than one day hrs. min.

9. Birthplace 809 95X Sparks (MD)
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Robert Owens

13. Birthplace Virginia

14. Maiden name Mary Eliz Evans

15. Birthplace Virginia

16. Informant Mrs Sarah Scott
 Address 1015 95X

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec 12-1947
 (month) (day) (year)
 Cemetery or crematory Int Calvary Cemetery
 Location A. A. Co. Ind.

18. Funeral director Robert E Williams
 Address 1515 Mt Eldridge St

19. Dec 10 19 47 X W Hedrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7th 1947 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947 1947 to Dec 7th 1947

and that I last saw him alive on Dec 7-47 1947

Immediate cause of death Cerebral apoplexy

DURATION

2 hrs.

Due to Hypertension

Due to Unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE J. H. Thomas M.D.
Funerary St. Md. M. D. or other

Address 128/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

County Baltimore
 City or town Raspeburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
602 Elmwood Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.
 City or town Raspeburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 602 Elmwood Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

HERBERT E. FRANCIS

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Carrie O. Beall
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) March 2nd, 1884
 8. AGE: Years Months Days If less than one day
63 9 15 hrs. min.

9. Birthplace Balto. Co., Md.
 (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business retired

12. Name James A. Francis

13. Birthplace Harford Co., Md.

14. Maiden name Emma V. Henry

15. Birthplace Balto. Co., Md.

16. Informant Mrs. H. E. Francis

Address 602 Elmwood Rd., Balto. 6, Md.

17. burial Date thereof Dec. 20, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Camp Chapel

Location Balto. Co., Md.

18. Funeral director Lassiter Funeral Home

Address 7401 Belair Road

19. Dec - 19 19 47 Imm. G. L. Reynolds
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17th, 19 47 at 2:52 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11, 47 to Dec 17, 47
 and that I last saw him alive on Dec 16, 47 19 47

Immediate cause of death..... DURATION

Chronic Degenerative Nephrosis

Due to Calculi Kidney

Due to Calculi Kidney

Other conditions Sarcoma. Sin.

(Include pregnancy within 8 months of death)

Major findings of operations See for Sarcoma Date of op. Dec 15-16-17

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Kerr Insley M. D. or other

Address 2536 E. 3rd St. Date signed 12-18-47

RECEIVED

DEC 27 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10904

Reg. Dist. No. 41

1. PLACE OF DEATH:

County Baltimore
 City or town Dundalk
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Baltimore
 City or town Dundalk
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6752 Woodley Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Ida M. Francis

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow
 6. (b) Name of husband or wife Samuel G. Francis
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) September 13, 1862
 8. AGE: Years 85 Months 3 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Co., md.
 (Town, county, and state)

10. Usual occupation none

11. Industry or business _____

12. Name Washington Sherman

13. Birthplace Baltimore Co., md.

14. Maiden name Elmira Van Horn

15. Birthplace Doylestown, Pa.

16. Informant Mrs. Frederick E. Luffy

Address 6752 Woodley Road, Dundalk

17. Burial Date thereof Dec. 31, 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Woodlawn

Location Woodlawn, Balto. Co., md.

18. Funeral director Roland L. Fisher

Address 2112 Dundalk Ave.

19. 1730747 19 12 31 1947
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 19 47, at 6:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 45 to Dec 27 19 47, and that I last saw him alive on Dec 27 19 47.

Immediate cause of death myocarditis, acute DURATION 3 days

Due to arteriosclerosis 10 yrs

Due to myocarditis chronic 2 yrs.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE David H. Audley M.D. M. D. or other

Address 2 Kingship Rd Dundalk md Date signed 12/30/47

RECEIVED

JAN 7 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Harding
3805
4810 Belair Road

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

10905

1. PLACE OF DEATH:
County..... Overlea
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
7422 Brookwood Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Overlea
City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 4404 Cooke Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
Theresa K. Frank

3. (b) Social Security Number

4. Sex..... female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... widowed
6.(b) Name of husband or wife..... Anthony John
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.)..... Dec. 21, 1891
8. AGE: Years..... 56 Months..... 0 Days..... 6 If less than one day..... hrs. min.

9. Birthplace..... Baltimore, Md.
(Town, county, and state)
at home
10. Usual occupation.....
11. Industry or business.....
FATHER 12. Name..... John L. Butt
13. Birthplace..... Md.
MOTHER 14. Maiden name..... Theresa K.
15. Birthplace..... Md.

16. Informant..... Mrs. Katherine Polly
Address..... 7422 Brookwood Road, 6
17. Burial Date thereof..... 12-30-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Holy Redeemer
Location..... Baltimore
18. Funeral director..... Leonard J. Ruck
Address..... 5305 Harford Road, 14
19. 12/30 19 47 A-M-Baron
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 27 19 47, at..... M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 19 44 to 12/27 19 47
and that I last saw him alive on 12/26 19 47
Immediate cause of death..... Cardiac Failure
DURATION
4 days.
Due to..... Cerebral spinal Sclerosis 3 years.
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?

23. SIGNATURE..... J.S. Harding M. D. or other
Address..... 3805 Belair Rd Date signed..... 12/29/47

DEC 31 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

10906

32

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
City or town Pikesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Catherine Robt Nursing Home Essex Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 25 Somerset Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Anna H. Freeman

3. (b) Social Security Number

4. Sex Female 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Late Marion Freeman

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1877. 6. (c) If alive, give age years

8. AGE: Years 69 Months 11 Days 17 It less than one day hrs. min.

9. Birthplace N. J. (Town, county, and state)

10. Usual occupation H. W.

11. Industry or business

12. Name James McHair

13. Birthplace Ireland

14. Maiden name Mary Gormley

15. Birthplace Ireland

16. Informant Herbert W. Freeman

Address 35 Somerset Rd.

17. Burial Date thereof Dec. 9/47. (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Louisa Pl.

Location 3801 Frederick Rd.

18. Funeral director Harry H. Witke

Address 4101 Edmondson Ave.

19. 12-8-47 19 888 Melhals (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6/47. 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 4. 19 47. to Dec. 5. 19 47.

and that I last saw h. s. c. alive on Dec. 5. 19 47.

Immediate cause of death (1) - cerebral hemorrhage

Due to

Due to

Other conditions Pneumo - Pneumonia - 3 days.

(Include pregnancy within 3 months of death)

Major findings of operations done Date of op.

Autopsy results done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

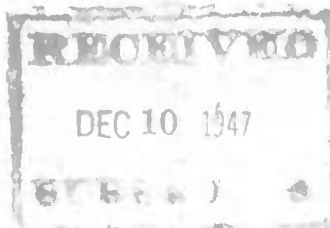
23. SIGNATURE Carl L. Chambers. M.D. M. D. or other

Address 4108 Liberty Hts. Ave Date signed Dec 8/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 44

1. PLACE OF DEATH:

(a) Baltimore City, Maryland *Middle River*(b) Street address *Box #331, Route 13,*

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) *life*

3 (a) FULL NAME

Josephine Anna Fuller

3 (b) If veteran, name war

3 (c) Social Security Account

4. Sex

female

5. Color or race

white

6 (a) Single, married, widowed, or

*divorced. married*6 (b) Name of husband or wife *William E. Fuller*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Feb. 22, 1891*

8. AGE: Years

Months

Days

If less than one day

56

hr.

min.

9. Birthplace *Baltimore, Md.*

(Town, county, and state)

10. Usual Occupation *Housewife*

11. Industry or business

FATHER

12. Name

Svehla

13. Birthplace

Unknown

MOTHER

14. Maiden Name

;

15. Birthplace

16 (a) Informant *William E. Fuller - husband*(b) Address *Box 331, Route 13, Baltimore, Md.*17 (a) *Burial*(b) Date thereof *12/18/47*

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory *Oak Lawn*Location *Eastern Ave. Rd. Baltimore, Md.*18 (a) Funeral director *Charles E. Schimunek*(b) Address *2601-3-5 E. Madison Street*19 (a) *Dec 11-47*(b) *A. W. Hedrick*

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE OF DECEASED:

(a) State *Md.*(b) County *10907*(c) City or town *Baltimore - 21 - Md.*

(If outside city or town limits, write RURAL and give town)

(d) Street No. *Box #331, Route #13*

(if rural give location)

(e) Citizen of foreign country? *no*

(Yes or No)

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH *12/19/47* 19 *47*, at *1207 P.*

21. I certify that death occurred on the date above stated; that I attended

deceased from *6/15* 19 *47*, to *12/17* 19 *47*and that I last saw him alive on *12/16* 19 *47*.

Immediate cause of death

Chronic Nephritis

Duration

5 yrs

Due to

Due to

Other Conditions

*Hypertension**2 yrs*

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

PHYSICIAN

Underline the cause to which death should be charged statistically.

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at *M*

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

P. W. Hedrick

M. D.

Address *11 S. Ches St* Date signed *12/19/47*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH:

County BaltimoreCity or town Sparks Pt.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Sparks Pt.
(If outside city or town limits, write RURAL and give nearest town)Street No. 374
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

4. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 5th 19258. AGE: Years 22 Months 3 Days 12 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Bookkeeper Apprentice11. Industry or business Beth Steel Co., -12. Name Robert Furrow13. Birthplace Baltimore, Md.14. Maiden name Emily J. Furrow15. Birthplace Baltimore, Md.16. Informant John B. ConnollyAddress 374 Sparks Pt. Rd.17. (Burial, cremation, or removal, Which?) Date thereof 12-17-47
(month) (day) (year)Cemetery or crematory St. Ignace CemeteryLocation St. Ignace Cemetery18. Funeral director John B. ConnollyAddress 410 E. Baltimore St.19. (Date rec'd by registrar) 12-17-47 Registrar John B. Connolly

3. (b) Social Security Number

219-183-198

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17th 1947 at 12:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19____, to 19____

and that I last saw h. _____ alive on 19____

Immediate cause of death Compensated Communitarian Fracture of PelvisDue to Shock & blue damperDue to no open heart # 3

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12-17-47Where did injury occur? Sparks Pt. - Baltimore, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) IndustryMeans of injury Shock across back Injured at work? Yesc damper23. SIGNATURE MB Waver M.D.Address Sparks Pt. - Baltimore, Md. Date signed 12/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

According to Dr. Ensor the definite age is unknown.
1/16/48 .dm

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10999 37
Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Towson
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 monthsHospital, institution, or street address where death occurred:
Baltimore County HomeHow long in hospital or institution? 9 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Gaither

3. (b) Social Security Number

✓

4. Sex male5. Color or race col6. (a) Single, married, widowed, or divorced6. (b) Name of husband or wife Mrs Eliza Hollins Gaither7. Birth date of deceased (mo., day, yr.) * Mar. 12, 18698. AGE: Years 78 Months 9 Days If less than one day hrs. min.9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Farm Laborer

11. Industry or business

12. Name Evam Gaither13. Birthplace Maryland14. Maiden name Matilda n.15. Birthplace Maryland16. Informant Mrs Rosa GaitherAddress Randallstown Md.17. Burial Date thereof Dec 14 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Johnsville CemLocation Johnsville Md.18. Funeral director Harry WeerAddress Sykesville Md.19. Dec. 12 19 47 M. J. Whitcomb
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 19 47, at 8:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 19 47 to Dec 12 19 47and that I last saw him alive on Dec 11 19 47Immediate cause of death Cerebral Tumor.

DURATION

9 mo.

Due to

Due to

Other conditions Asphyxiation -

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Wm. C. Ensor M.D.

M. D. or other

Address Cockeysville Md. Date signed 12/12/47



REG. No. 2564

WILMER C. ENSOR, M. D.

COCKEYSVILLE, MARYLAND

PHONE, COCKEYSVILLE 9

DATE

1/14/48-

PATIENT'S
NAME

ADDRESS

R

To whom it may concern,
I hereby certify that
Geo. Gaither - of Spkeville Ind -
was under my medical care at
Batts. Co. Home. and that he was
in such a mental state - that he
did not know his age - Respt. submitted

SENCINDIVER'S DRUG STORE

COCKEYSVILLE, MARYLAND

PHONE, COCKEYSVILLE 93

Wilmer C. Ensor M. D.

definite

no 50 20
no 20 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Ridgely
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 14 years (place of employment)
 Hospital, institution, or street address where death occurred: _____
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City
 City or town Baltimore City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 340 Bloom St.
 (If rural, give LOCATION) ☒
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary E. Garrett

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife William
 7. Birth date of deceased (mo., day, yr.) Aug. 10, 1879 6. (c) If alive, give age _____ years
 8. AGE: Years 68 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Harford Co. Md.
 (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business _____

12. Name A. W. Bentley

13. Birthplace Harford Co. Md.

14. Maiden name Johnson

15. Birthplace Harford Co. Md.

16. Name Miss Beulah J. Garrett

Address 340 Bloom St.

17. Burial Dec. 14, 1947

(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Mt. Zion

Location Baltimore, Md.

18. Funeral director Rev. Geo. H. Halland

Address 1631 Duval Hill Ave

19. 12-12-47 A. W. Hedrick

(Date rec'd by registrar) _____ Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1947 at 5-20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____

and that I last saw him alive on _____

Immediate cause of death Heart disease, chronic DURATION 12/11/47
vascular, with coronary occlusion

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Bollin C. Hudson 12/11/47

Address Towson Md Date signed 12/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10911 44

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Baltimore Sparrows Pt.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 52 Years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore
 City or town..... Baltimore Sparrows Pt.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. North Point Road and Wise Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

ANNA GAWLIK

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married
 8. (b) Name of husband or wife..... Cazmer Gawlik
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... November 24, 1882
 8. AGE: Years..... 65 Months..... 0 Days..... 13 If less than one day..... hrs. min.

9. Birthplace..... Germany
 (Town, county, and state)
 10. Usual occupation..... Domestic
 11. Industry or business.....
 12. Name..... Ferdinand Koch
 13. Birthplace..... Germany
 14. Maiden name..... Mary (Unknown)
 15. Birthplace..... Germany

16. Informant..... Cazmer Gawlik
 Address..... North Point Road and Wise Ave.
 17. Burial..... Burial Date thereof..... 12 20 47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Oak Lawn
 Location..... 8200 Eastern Ave.
 18. Funeral director..... Lilly and Zeiler, Inc.
 Address..... 403 S. Wolfe St. Balto. 31, Md.
 19. Dec 18, 1947 H. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec 17 19 47, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec 16 19 47, to Dec 17 19 47
 and that I last saw her alive on Dec. 16 19 47

Immediate cause of death..... Cerebral Haemorrhage DURATION
arteriosclerosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... Denis J. McGrath M. D. or otherAddress..... 27223 Harford Rd Date signed..... 12/18/47

Dr. DAVIS McGRATH

7223 HARFORD RD.

RES. CLIFTON 4155

OFF. CLIFTON 4812

PLEASE WRITE PLAINLY, WITH INK, FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

156 N. Milton Ave. Rm 2198 - Tel 5220
 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10912

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.
 City or town Rosedale
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
7910 Elmhurst Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto
 City or town Rosedale
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7910 Elmhurst Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William Gera

3. (b) Social Security Number

215-09-9696

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mary B. Gera
 7. Birth date of deceased (mo., day, yr.) Sept 8th 1904 6. (c) If alive, give age _____ years
 8. AGE: Years 43 Months 3 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Hungary
 (Town, county, and state)
 10. Usual occupation Butcher
 11. Industry or business Corkran Hill Co.
 12. Name John Gera
 13. Birthplace Hungary
 14. Maiden name Anna (Unknown)
 15. Birthplace "

16. Informant Mary B. Gera
 Address 7910 Elmhurst Ave - Rosedale
 17. Burial Date thereof 12/13/47
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Zion Lutheran
 Location Golden Ring Rd.
 18. Funeral director William Cook Inc.
 Address 1217 St. Paul St.
 19. 12/12 19 47 B. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10th 19 47 at 2¹⁵ P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7 - 1947 to Dec 10 - 47
 and that I last saw him alive on Dec 2 - 10 - 1947
 Immediate cause of death Myocardial infarction DURATION 2 yrs.
Myocardial infarction
 Due to Plaque, Effusion
 Due to Acute myocardial infarction
 Other conditions Myocardial insufficiency
Coronary Arteriosclerosis
 (Include pregnancy within 3 months of death)
 Major findings of operation Cor. Ar. - Myocardial infarction
Plaque Effusion - Coronary Arteriosclerosis
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, pub'c place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE W. G. Gera M. D. or other _____
 Address 156 N. Milton Ave Date signed 12/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10913

39

1. PLACE OF DEATH:

County Baltimore
 City or town Jowson
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.
 City or town Jowson
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 215 Courtland Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary E. Goerner

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Wm. E. Goerner Sr.
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) Feb. 23-1865
 8. AGE: Years 82 Months 10 Days 15 (if less than one day) hrs. min.

9. Birthplace Baltimore Md.
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business

MOTHER FATHER
 12. Name John Gephart
 13. Birthplace Germany
 14. Maiden name Not known
 15. Birthplace Germany
 16. Informant Wm. E. Goerner Sr.
 Address 521 N. Street St.
 17. Burial (Burial, cremation, or removal) Which? Burial Date thereof Dec. 10-47
 (month) (day) (year)
 Cemetery or crematory Baltimore Cemetery
 Location North Ave. + Gay St.
 18. Funeral director John A. Miller
 Address 2334 Jefferson St.
 19. 12/7 1947 J. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7th 1947 at 5:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Summer 1944 to Dec. 7th 1947
 and that I last saw h. er alive on Dec. 7, 1947 19

Immediate cause of death

Cardiac Failure

DURATION

3 weeks

Due to

Arteriosclerotic

?

Cardio-Vascular disease

Due to

Other conditions

Ana sarca3 weeks

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. A. Sedlak, M.D. M. D. or other
210 W. Penna. Ave
 Address Jowson, Md. Date signed 12/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltoCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

11 Riverside Drive

How long in hospital or institution?

3. (a) FULL NAME

Carrie C. Gray

3. (b) Social Security Number

4. Sex 7 5. Color or race W 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife John Gray6. (c) If alive, give age 53 years7. Birth date of deceased (mo., day, yr.) Aug 31 - 18918. AGE: Years 36 Months 2 Days 9 If less than one day

8. hrs. min.

9. Birthplace Balto Md
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name Red Kasper13. Birthplace Balto14. Maiden name Clark

15. Birthplace

16. Informant Mr John GrayAddress 11 Riverside Drive17. (Burial, cremation, or removal, Which?) Burial Date thereof 12/23/47
(month) (day) (year)Cemetery or crematory MorelandLocation Section 1018. Funeral director John B. ConnollyAddress 418 Eastern Ave19. 12/23 19 47 John B. Connolly
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltoCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 Riverside Drive
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 19 47 at 4:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 19 46, to Dec 22 19 47and that I last saw her alive on Dec 21 19 47Immediate cause of death Cardio-respiratoryfailureDue to GeneralizedmetastasesDue to Carcinoma cervixuteri

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph Vicali MDAddress 422 Eastern Ave Date signed 12/23/47

M. D. or other

RECEIVED
DEC 29 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10915

Reg. Dist. No.

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Fort Howard, Md.How long in hospital or institution? 20 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 2803 Biddle Street
(If rural, give LOCATION)2. (a) If veteran, name war WW I

3. (a) FULL NAME

JOHN D. GRAY

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Rebecca Gray6. (c) If alive, give age 52 years7. Birth date of deceased (mo., day, yr.) 10-12-858. AGE: Years 62 Months 2 Days 1 If less than one day
hrs. min.9. Birthplace AnnaArundel Co., Md.
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name Robert Gray13. Birthplace Maryland14. Maiden name Ella Boyd15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. HospAddress Fort Howard, Md.17. Burial Date thereof 12-16-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director William CookAddress St. Paul at Preston St., Balto., Md.19. 12-75-47 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 19 47 at 4:10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 23, 19 47 to December 13, 19 47and that I last saw him alive on December 13, 19 47Immediate cause of death Cardiac dilatation and Hypertrophy DURATION ?Due to Coronary Arteriosclerosis ?

Due to

Other conditions Arteriosclerosis, general-ized ?
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard Land, M.D. M.D. or otherAddress VAH, Fort Howard, Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

 10916
 Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Beltsville Road
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
47 Hollins Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town Beltsville
(If outside city or town limits, write RURAL and give nearest town)Street No. 17 Hollins Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth A. Grebe

3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Charles

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug - 27 - 18868. AGE: Years 61 Months 11 Days 11 It less than one day hrs. min.9. Birthplace Balto. Co. Md.
(Town, county, and state)10. Usual occupation Housewife11. Industry or business W. H. Harman12. Name James P. Grebe13. Birthplace Balto14. Maiden name Elizabeth Grebe15. Birthplace Balto16. Informant Mr. Walter GrebeAddress 47 Hollins Rd.17. (Burial, cremation, or removal. Which?) Burial Date thereof 12/30/47
(month) (day) (year)Cemetery or crematory GreenwoodLocation Greenwood18. Funeral director John B. GrebeAddress 422 Eastern Ave. Balto 21, Md.19. 12/29/47 19 47 John B. Grebe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 19 47 at 1:30 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1st 19 46 to December 27 19 47
and that I last saw him alive on Dec. 27 19 47Immediate cause of death Arterio-sclerotic Hypertensive
Cardio-vascular-renal disease

DURATION

2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations nil

Date of op.

Autopsy results nil

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. White, M.D.Address 422 Eastern Ave. Balto 21, Md. Date signed 12/29/47

RECEIVED

DEC 29 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10917

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Middle River, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 44 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Middle River, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1133 Orems Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

MARGARET A. GREEN

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife James E. Green
 7. Birth date of deceased (mo., day, yr.) June 3rd, 1873
 6.(c) If alive, give age _____ years
 8. AGE: Years 74 Months 6 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation at home
 11. Industry or business _____

MOTHER FATHER
 12. Name Louis Graham
 13. Birthplace Baltimore, Md.
 14. Maiden name Louise Frank
 15. Birthplace Germany

16. Informant Miss Ethel Green
 Address 1133 Orems Road
 17. burial Date thereof 12/24/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Orems Methodist
 Location Balto. Co. Md.
 18. Funeral director Lassahn Funeral Home
 Address 7401 Belair Road
 19. 12/23 19 47 A.W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21st, 1947, at 7:40p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 25 1947, to December 21 1947, and that I last saw her alive on December 21 1947.
 Immediate cause of death Coronary occlusion

Due to Hypertensive arteriosclerotic heart disease
 Due to _____
 Other conditions Terminal bronchopneumonia 24 hrs
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Jack Wexler, M.D.
 Address 208 E. ... (20) Date signed _____
 M. D. or other _____

Change of time of residence
and age verified by phone
conversation with Dr. Rahn
12/30/47 PC.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 10918 42

1. PLACE OF DEATH:

County BALTIMORE
City or town ARBUTUS
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 63 6/8/45 ☒
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County BALTIMORE
City or town ARBUTUS
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 WAELCHLI
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

ADOLF K. GUNTHER

3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED
6. (b) Name of husband or wife DAISY T (GAKEN) JACOBS
7. Birth date of deceased (mo., day, yr.) JAN. 24, 1874 6. (c) If alive, give age years
8. AGE: Years 73 7/2 Months 10 Days 27 If less than one day hrs. min.

9. Birthplace GERMANY
(Town, county, and state)
10. Usual occupation RETIRED
11. Industry or business
12. Name WILLIAM GUNTHER
13. Birthplace GERMANY
14. Maiden name PAULINE
15. Birthplace GERMANY

16. Informant MRS ADOLF K GUNTHER
Address 11 WAELCHLI AVE - ARBUTUS
17. BURIAL Date thereof DEC. 28, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory WESTERN

Location EDMONDSON AVE - LONEWOOD
18. Funeral director Nancy H. Witzke
Address 4101 Edmondson Ave

19. 12/23 1947 D.W. Hedrick
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 21 1947 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1947 to Dec 21 1947
and that I last saw him alive on Dec 21 1947

Immediate cause of death Pneumonia
DURATION

Due to
Due to

Other conditions Chronic valv heart dis
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dr. Rahn M. D. or other
Address 1732 Poplar St Date signed 12/22/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

125 Riverside Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town Essex
(If outside city or town limits, write RURAL and give nearest town)Street No. 125 Riverside Rd.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Guthrie

3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

W.

6. (b) Name of husband or wife

William D. Guthrie

7. Birth date of deceased (mo., day, yr.)

Jan. 27 - 1870

6. (c) If alive, give age years

8. AGE:

77

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Balto. Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

At Home

FATHER

12. Name

Charles E. Guthrie

13. Birthplace

Md.

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mr. Frank Bobart

Address

125 Riverside Rd.

17. (Burial, cremation, or removal, Which?)

Date thereof

12-16-47
(month) (day) (year)

Cemetery or crematory

Oak Lawn

Location

Eastern Ave.

18. Funeral director

John B. Connolly

Address

415 Eastern Ave.

19.

12/15/47
(Date rec'd by registrar)

18.

John E. Connolly
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1947 at 9:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1946 to Dec. 13 1947and that I last saw her Dec. 13 1947 alive on

Immediate cause of death

Arteriosclerotic Cardia
Insular - Renal Renal

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

no

Date of op.

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James H. White M.D.

M. D. or other

Address 422 Eastern Ave., Balto., Md. Date signed 12/15/47

RECEIVED

DEC 16 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10920

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Maryland
 How long in hospital or institution? 30 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2204 Orleans Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW I

3. (a) FULL NAME

JAMES F. HARDESTY

3. (b) Social Security Number

218-26-4581

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Adale Hardesty
 7. Birth date of deceased (mo., day, yr.) 1-7-1893 6.(c) If alive, give age 52 years
 8. AGE: Years 54 Months 11 Days 24 If less than one day
 hrs. min.

9. Birthplace Prince Frederick, Maryland
 (Town, county, and state)
 10. Usual occupation Unemployed
 11. Industry or business

12. Name Charles Hardesty
 13. Birthplace Maryland
 14. Maiden name Rose Card
 15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Ft. Howard, Maryland

17. Burial Date thereof 1 3 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
Baltimore, Maryland
 Location Howard M. Blight Jr.
Howard Blight, Funeral Home
4914 Belair Rd., Balto., Md.
 18. Funeral director
 Address

19. 1/2 48 A.W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31, 19 47 at 3:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 1, 19 47, to December 31, 19 47
 and that I last saw him alive on December 31, 19 47

Immediate cause of death
Carcinoma of Bronchus, left
Metastatic to left kidney
 DURATION
1 year
plus

Due to
 Due to
 Other conditions Abscesses, left lung due
to above.
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results Substantiated above.
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE C.E. Shaw, M.D. M. D. or other
 Address V.A.H. FORT HOWARD, MD Date signed 12-31-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 10921 30
 Reg. Dist. No. 100

1. PLACE OF DEATH: County <u>Baltimore</u> City or town <u>Catonsville 28, Maryland</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>12 days</u> Hospital, institution, or street address where death occurred: <u>Spring Grove State Hospital</u> How long in hospital or institution? <u>12 days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Prince George</u> City or town <u>Hyattsville</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>2011 Roanoke Street</u> (If rural, give LOCATION) 2.(a) If veteran, name war <u>✓</u>	
--	--	---	--

3. (a) FULL NAME	3. (b) Social Security Number
-------------------------	--------------------------------------

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Widowed</u>
-------------------------	----------------------------------	---

6.(b) Name of husband or wife <u>William Harding</u>

7. Birth date of deceased (mo., day, yr.) <u>November 5, 1873</u>	6.(c) If alive, give age years
--	---

8. AGE:	Years	Months	Days	If less than one day
<u>74</u>	<u>1</u>	<u>6</u> hrs. min.

9. Birthplace <u>Charles County, Maryland</u> (Town, county, and state)

10. Usual occupation <u>Former housewife</u>

11. Industry or business <u>Domestic</u>

12. Name <u>William Johnson</u>

13. Birthplace <u>Maryland</u>

14. Maiden name <u>Ellen Mathoney</u>
--

15. Birthplace <u>Maryland</u>

16. Informant <u>Hospital records</u>
--

Address <u>Spring Grove State Hospital</u>

17. <u>BURIAL</u> (Burial, cremation, or removal. Which?)	Date thereof <u>12-13-47</u> (month) (day) (year)
--	--

Cemetery or crematory <u>Old Fields</u>
--

Location <u>Hughesville Md</u>

18. Funeral director <u>ELMER M. QUADE</u>

Address <u>Hughesville Md.</u>

19. <u>12-12</u> (Date rec'd by registrar)	19. <u>47</u>	<u>Julia H. Perry</u> Registrar
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MEDICAL CERTIFICATION

 20. DATE OF DEATH December 11 1947 at 8:35 a.m.

 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 29 1947 to December 11 1947

 and that I last saw her alive on December 11 1947

Immediate cause of death <u>Myocardial failure (acute)</u> <u>Gastritis (acute)</u>	DURATION <u>1.5 mints.</u> <u>2 days</u>
---	--

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

 Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

 Where did injury occur?
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

 23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

 Address Spring Grove State Hosp. Date signed Dec. 11, 1947

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DEC 15 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10923

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County... Baltimore

City or town... Parkville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

M

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Barbara Mae

7. Birth date of deceased (mo., day, yr.)

April 30, 1885

6. (c) If alive, give age years

8. AGE:

61

Years

7

Months

26

Days

hrs.

min.

9. Birthplace

Baltimore Md.

(City, county, and state)

10. Usual occupation

Real Estate

11. Industry or business

FATHER

12. Name

Major G. Harris

13. Birthplace

Va.

MOTHER

14. Maiden name

Mary Elizabeth

15. Birthplace

16. Informant

Mrs. Barbara M. Harris

Address

3801 Taylor Ave

17.

(Burial, cremation, or removal, Which?)

Date thereof

12/30/47

Cemetery or crematory

Berkwood

Location

Taylor Ave

18. Funeral director

J. Luck

Address

5305 Hayford Road

19.

(Date rec'd by registrar)

12/30

19

47

A. M. Bacon

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Baltimore

City or town... Parkville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2801 Taylor Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

520345804

MEDICAL CERTIFICATION

20. DATE OF DEATH... Dec. 26 1947 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Home 19 to 19

and that I last saw him on 19

Immediate cause of death... Heart disease, angina

Coronary atherosclerosis Sudden 12/26/47

Due to...

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE

Address... Towson Md Date signed 12/26/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 31 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

10922

92d

1. PLACE OF DEATH:

County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Catonsville
(If outside city or town limits write RURAL and give nearest town)Street No. Hunter Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Raymond Nelson Harris

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Divorced6. (b) Name of husband or wife Madelaine R.7. Birth date of deceased (mo., day, yr.) Dec. 22, 1907 8. (c) If alive, give age _____ years8. AGE: Years 40 Months _____ Days _____ It less than one day _____ hrs. _____ min.9. Birthplace Catonsville, Md.
(Town, county, and state)10. Usual occupation Chauffeur

11. Industry or business

12. Name Daniel Harris13. Birthplace Catonsville, Md.14. Maiden name Mary Fossett15. Birthplace Charlottesville, Va.16. Informant Mrs. Helen TurnerAddress Hunter Ave.17. Burial Date thereof Jan 2, 1948
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Weston StarLocation Catonsville, Md.18. Funeral director Mrs. Susan A. HallAddress 1631 Druid Hill Ave.19. 117 48 A. W. Helrich
(Date received by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1947 at 4 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1947 to Dec 31, 1947and that I last saw him alive on Dec 31, 1947Immediate cause of death Cardiovascular DURATION 12 hrs.

Due to _____

Due to _____

Other conditions Dropsy

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE [Signature] M. D. or other _____Address [Signature] Date signed Jan 2, 1948

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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1944

RECORDED
JAN 7 1948
BY HEATH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

10924

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Balto. Co
 City or town Catonville
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 3 yr.

3. (a) FULL NAME

Opheelia Johnston Hart4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Apr 8 18618. AGE: Years 86 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Tenn.
(Town, county, and state)

10. Usual occupation

11. Industry or business Retired12. Name Opheelia Johnston13. Birthplace Tenn.14. Maiden name Josephine Lorman15. Birthplace Md.16. Informant Mr. H. W. TristoeAddress Catonville Md.17. Burial Date thereof 12/22/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium Episcopal CemeteryLocation Bethesda Md.18. Funeral director Edw. J. MacNabbAddress Catonville Md.19. 12/27 1947 A. W. Dedrich
(Date rec'd by Registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.
 City or town Catonville 28 Ward No. _____
 (If outside city or town limits, write RURAL NEAR and give town)
 Street No. Frederick Rd.
 (If rural give LOCATION)

2 (a) IF VETERAN, NAME WAR _____

3. (b) Social Security Number _____

MEDICAL CERTIFICATION

2D. DATE OF DEATH Dec 20 19 47 at 2³⁰ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 19 47, to Dec 20 19 47,
 and that I last saw him alive on Dec 20 19 47

Immediate cause of death

Heart block

DURATION

2 daysDue to Arteriosclerotic
cardiovascular disease UnknownDue to Generalized, severe
arteriosclerosis Unknown

Other conditions

Unknown

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline
 the cause to which
 death should be
 charged statisti-
 cally.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur?

(City or town)

(County)

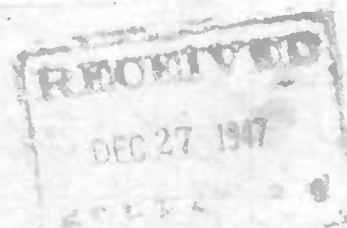
(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE Stephen Lee Magness M.D. M. D. or otherAddress Catonville 28, Md. Date signed Dec 22 '47



CNO
COPY SENT TO LOCAL REGISTRAR No. _____ DATE 12/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 10925 30

1. PLACE OF DEATH:

County Baltimore
 City or town Charmersville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
510 Charming Cross
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For persons under 18 years of age, give residence of mother)

State MD County Montg.
 City or town Pennington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Mary Elizabeth Heavener

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Gen USA Heavener SS
 7. Birth date of deceased (mo., day, yr.) Nov 26 1894 8. (c) If alive, give age _____ years
 8. AGE: Years 73 Months 0 Days 26 It less than one day _____ hrs. _____ min.

9. Birthplace Baltimore MD
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business _____

12. Name Thomas J. Heavener13. Birthplace Baltimore MD14. Maiden name Martha J. Cochran15. Birthplace Baltimore MD16. Informant Wm J. SmithAddress 510 Charming Cross17. Burial Date thereof 12/24/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Grand RidgeLocation Charmersville MD18. Funeral director William G. SmithAddress 1219 17th St NW19. 12/24 19 47 9:45 AM
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 19 47 at 12:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 21 19 47 to Dec 22 19 47
 and that I last saw him/her alive on Dec 21 19 47
 Immediate cause of death Heart failure
 Due to Hypertensive arteriosclerotic cardiovascular disease
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

DURATION

10 yrs.

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John A. Heavener Jr. M. D. or other _____Address 20 E. Preston St - Balt Date signed 23 Dec 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10926

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 yrs.
 Hospital, institution, or street address where death occurred: _____
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Pikesville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 403 Reisterstown Road
 (If rural, give LOCATION)
 2. (a) If veteran, same war _____

3. (a) FULL NAME

Joseph Rowe Henneberger

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, or divorced married

6. (b) Name of husband or wife Elsie May Henneberger

7. Birth date of deceased (mo., day, yr.) April 21 - 1878 6. (c) If alive, give age 64 years

8. AGE: Years 69 Months 9 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Waynesboro Pa.
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Hiram Henneberger13. Birthplace Waynesboro Pa.14. Maiden name Elizabeth Hoover15. Birthplace Waynesboro Pa.16. Informant Elsie May HennebergerAddress 403 Reisterstown Rd. Pikesville, Md.

17. Burial Date thereof 12/29/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory David RidgeLocation Pikesville, Md.18. Funeral director Frank H. NewellAddress Pikesville, Maryland

19. 12-2-7- 19 47 Dr. E. E. Nichols
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25- 19 47 at _____ M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12/11 19 47 to 12/25 19 47

and that I last saw him alive on 12/25 19 47

Immediate cause of death _____

DURATION

Cerebral Thrombosis 3 days

Due to congestive heart failure 2 days

Due to chronic atherosclerosis ?

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Flora E. Nichols M. D. or other

Address 204 N. Charles St. Date signed 12/29/47

RECEIVED

DEC 29 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10927 43

1. PLACE OF DEATH:

County Baltimore
 City or town Baltimore - Raspeburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Raspeburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3 Elmont Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

EDWARD F. HERRMANN, Sr.

3. (b) Social Security Number

216-07-0044

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Annie V. Herrmann
 7. Birth date of deceased (mo., day, yr.) March 9th, 1884
 6.(c) If alive, give age _____ years
 8. AGE: Years 63 Months 8 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)
 10. Usual occupation Printer
Waverly Press
 11. Industry or business _____
 12. Name Henry Herrmann
 13. Birthplace Germany
 14. Maiden name Unknown
 15. Birthplace _____

16. Informant Mrs. Edward F. Herrmann, Sr.
3 Elmont Ave.
 Address _____
 17. burial Date thereof 12/22/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Parkwood
Baltimore, Md.
 Location _____
 18. Funeral director Lassahn Funeral Home
 Address 7401 Belair Road

19. Dec - 19 19 47 Ms. A. T. Pappas
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1947 at 1:22 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7, 1947 to Dec. 18, 1947
 and that I last saw him alive on Dec. 18, 1947

Immediate cause of death Toxic Absorption DURATION 2 days
 Due to Carcinoma of Rectum 2 years

Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Michael J. Danach M.D. M. D. or other _____
 Address 1 W. Overlea Ave. Date signed 12/18/47

RECEIVED
DEC 27 1947
SERIAL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10928

1. PLACE OF DEATH:
County Baltimore
City or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Maryland
How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1513 W. Lombard Street
(If rural, give LOCATION)
2. (a) If veteran, name war WW-I

3. (a) FULL NAME

CHARLES W. HERSHEY

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Bertha Mae Hershey
6. (c) If alive, give age 53 years
7. Birth date of deceased (mo., day, yr.) 9-4-89
8. AGE: Years 58 Months 3 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business
12. Name William Hershey
13. Birthplace Maryland
14. Maiden name Emma Dick
15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
Address Fort Howard, Maryland
17. Burial Date thereof 12 16 47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Maryland
18. Funeral director Howard Blight, Jr.
Address 4914 Belair Rd., Balte., Md.
19. 12-15 47
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 1947 at 11:05 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 5, 1947 to December 13, 1947
and that I last saw him in alive on December 13, 1947

Immediate cause of death Tuberculosis, pulmonary
bilateral, advanced DURATION 1 month

Due to _____

Due to _____

Other conditions 1. Carcinoma of colon, mod. Unknown
2. Arteriosclerosis, generalized & Unknown
Coronary, 3. Infarct, right cerebrum.

Major findings of operations _____

_____ Date of op. _____

Autopsy results Substantiated above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Richard Land M.D. M. D. or other
Address VAH, Fort Howard, Md. Date signed _____

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10929 33

1. PLACE OF DEATH:

County Baltimore
 City or town Owings Mills, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 31 yrs., 1 mo., 6 days
 Hospital, institution, or street address where death occurred:
Rosewood State Tr. School,
 How long in hospital or institution? 31 yrs., 1 mo., 6 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Baltimore
 City or town Owings Mills
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war No.

3. (a) FULL NAME

William Sylvester Hogan

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

9/6/15

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

31

1

6

hrs. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation inmate- Rosewood State Training School
 11. Industry or business

12. Name William H. Hogan13. Birthplace Maryland14. Maiden name ~~William~~ Marie Bolan15. Birthplace Maryland16. Informant William H. HoganAddress 1623 N. Gay Street

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 12/26/47

(month) (day) (year)

Cemetery or crematory ParkwoodLocation Taylor Avenue, Balto: Co. Md.18. Funeral director George J. Ruth, Inc.Address 1735 Harford Avenue

19. (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/47 19____ at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/22/4719____ to 12/23

19____ 47.

and that I last saw him alive on 12/23/47 19____Immediate cause of death Status Epilepticus

DURATION

1 dayDue to Epilepsy Idiopathicsince birth

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE N. G. Butler, M.D. M. D. or otherAddress Owings Mills, Md. Date signed 12/23/47

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 94a
 10930
 35-
 Reg. Dist. No.

1. PLACE OF DEATH:
 County Baltimore
 City or town Rural near Freeland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Penna County York
 City or town Rural near New Freedom
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1 mi. East of New Freedom
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME Edith Gertrude Houseman 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Wilson Houseman

7. Birth date of deceased (mo., day, yr.) September 1, 1881 6. (c) If alive, give age 67 years

8. AGE: Years 67 Months 3 Days 12 If less than one day
 hrs. min.

9. Birthplace New Freedom, Pa.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

12. Name Edgar Baughman

13. Birthplace York Co., Pa.

14. Maiden name Lydia Koller-

15. Birthplace Unknown

16. Informant Wilson Houseman

Address New Freedom, Pa. R.D.

17. Burial Date thereof Dec. 16, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory New Freedom

Location New Freedom, York Co., Pa.

18. Funeral director Jacob Harkensley

Address New Freedom Pa

19. Dec 14 19 47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 1947 at 6:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19 to 19
 and that I last saw him alive on 19

Immediate cause of death

Coronary artery disease

Due to head on accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. W. Franer M. D. or other

Address Parlerton, Ind. Date signed 12/14/47

RECEIVED

DEC 24 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

10931

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore
 City or town Delight nr Reisterstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 15 yrs
 Hospital, institution, or street address where death occurred:
Reisterstown Rd Delight
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Delight nr Reisterstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Reisterstown Rd
 (If rural, give LOCATION)
 2(a) If veteran, name war None

3. (a) FULL NAME

Harry Huff

3. (b) Social Security Number

None

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

6. (b) Name of husband or wife

Nettie May Huff6. (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.)

May 4 1871

8. AGE:

Years 76Months 6Days 29

If less than one day

hrs. min.

9. Birthplace

Harpers Ferry W Va

(Town, county, and state)

10. Usual occupation

Retired Bricklayer

11. Industry or business

-

FATHER

12. Name

Harrison Huff

13. Birthplace

Charlestown W Va

MOTHER

14. Maiden name

Catherine McNew

15. Birthplace

Chambersburg Pa

16. Informant

Mrs Nettie May Huff

Address

Reisterstown Rd Delight Md

17.

(Burial, cremation, or removal, Which?)

BurialDate thereof Dec 6 1947
(month) (day) (year)

Cemetery or crematory

Druid Ridge Cemetery

Location

Pikesville Md

18. Funeral director

Wm Berryman & Sons

Address

Reisterstown Md

19.

(Date rec'd by registrar)

Dec - 4 - 19 47Mary B. Schin
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

December 3 19 47 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-14-46
and 12-3-19-47 to 19 47
 and that I last saw h... alive on December 3 19 47

Immediate cause of death

Pulmonary Edema

Due to

Intermittent heart disease

Due to

Other conditions

Diabetes, chronic Sinusitis
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Walter Landon

M. D. or other

Address

Reisterstown Md

Date signed

12-4-47

UNITED STATES DEPARTMENT OF HEALTH

CENTRAL INTELLIGENCE

RECEIVED
DEC 9 1947

Evidence for the change of
year of birth raised above
on G 114. 12/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

9402

10932

44

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....Balto.

City or town.....Cress 21
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Poplar Rd. Bu 331, Cedar Beach.

How long in hospital or institution?

10 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....Same
(If outside city or town limits, write RURAL and give nearest town)

Street No.....Same
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

George Francis Hughes.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

Rosa Lee

7. Birth date of deceased (mo., day, yr.)

May 27 / 1877 / 1877

8. AGE:

Years

Months

Days

If less than one day

75

7

6

14

hrs.

min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

Bagger

11. Industry or business

Retired

FATHER

12. Name

William Hughes.

13. Birthplace

Baltimore.

MOTHER

14. Maiden name

Sarah Catherine Cole.

15. Birthplace

Baltimore Md.

16. Informant

Mrs. Evelyn M. Fuller (daughter)

Address

at home

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

12-13-47

Cemetery or crematorium

Woodlawn

Location

Liberty Heights

18. Funeral director

Charles E. Schumacher

Address

2601 E. Madison St.

19.

(Date rec'd by registrar)

Dec. 11 19 47

A. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Dec 10 19 47 at 8:12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Coronary accident

Due to.....

Due to.....Gangrene of leg
amputated below hip

Other conditions

Gangrene left heel.
(Include pregnancy within 6 months of death)

Major findings of operations

Date of op.....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town).....(County).....(State).....

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

Imbarmore M. D.
Deputy Medical Examiner
Address.....Balto Co. Annapolis Md 47014

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 10933
 Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Westowne
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Hood Nursing Home
5501 Edmondson Ave.,
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3612 Clifton Ave.,
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Isabelle
Emma Isabelle Ijams

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Edward C. Ijams
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) April 1, 1863

8. AGE: Years 84 Months 11 Days 15 hrs. min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

MOTHER FATHER 12. Name Washington Galt

13. Birthplace Baltimore, Md.

14. Maiden name Mary Perry

15. Birthplace Baltimore, Md.

16. Informant Mrs. Charles M. Harrison
 Address 3612 Clifton Ave.,

17. Burial Date thereof 12-19-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Loudon Park
 Location Baltimore, Md.

18. Funeral director St. Howard Strong
 Address 3207 W. North Ave.,

19. 12-18-47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

1.25

20. DATE OF DEATH December 16, 1947 at P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 - 1947 to Dec 16 - 1947
 and that I last saw him alive on Dec 16 - 1947

Immediate cause of death

Edema Lungs - DURATION 2 days

Due to Chronic myocarditis 5 yrs

Due to Arterio-Sclerosis - 10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. Gill Hall M.D. M. D. or other

Address 1631 E. North av Date signed Dec 16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10934

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 37 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland
 How long in hospital or institution? 37 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 404 Ostend Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war SAW ✓

3. (a) FULL NAME

WILLIAM JACKSON

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married—Separated
 6.(b) Name of husband or wife Bessie Jackson
 7. Birth date of deceased (mo., day, yr.) 1-1-75 6.(c) If alive, give age 47 years
 8. AGE: Years 72 Months 11 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Burton, Alabama
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Henry Jackson

13. Birthplace North Carolina

14. Maiden name Tillie Walter

15. Birthplace North Carolina

16. Informant Clinical Records, Vets. Adm. Hosp.
Ft. Howard, Maryland
 Address _____

17. Burial Date thereof Jan. 3, 1948
 (Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory W.F. Gathers Cem.

Location Balto.

18. Funeral director Katie Williams

Address Baltimore, Maryland

19. Jan. 3 19 48 E. W. Hedrick
 (Date rec'd by registrar) Registrar pusas

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 19 47 at 9:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 23, 19 47 to December 29, 19 47 and that I last saw him alive on December 29, 19 47

Immediate cause of death Uremia DURATION 2 Weeks

Due to Hypertrophy of median lobe of prostate Unknown

Due to _____

Other conditions Arterio and Arteriolar Nephrosclerosis Cardiac dilatation & Hypertrophy Unknown
 (Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE E. E. SHAW, M.D. M. D. or other _____

Address V.A.H. FORT HOWARD, MD. Date signed 12-31-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10935.

Reg. Diat. No. 38

1. PLACE OF DEATH: County..... <u>Carney</u> City or town..... <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>West Summit Avenue</u> How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Carney</u> City or town..... <u>Baltimore</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>West Summit Avenue</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>ANTHONY JAGER</u>				3. (b) Social Security Number			
4. Sex <u>male</u>		5. Color or race <u>white</u>		6. (a) Single, married, widowed, or divorced <u>single</u>		MEDICAL CERTIFICATION	
B. (b) Name of husband or wife				20. DATE OF DEATH <u>Dec. 19</u> 19 <u>47</u> at <u>104</u> M			
7. Birth date of deceased (mo., day, yr.) <u>Feb. 1891</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Dec. 12</u> 19 <u>47</u> to <u>Dec. 19</u> 19 <u>47</u> and that I last saw him alive on <u>Dec. 18</u> 19 <u>47</u> Immediate cause of death <u>Sp. myocarditis</u> <u>Ch. nephritis</u> <u>Coronary atherosclerosis</u>			
8. AGE: Years <u>56</u>		Months		Days		If less than one day hrs. min.	
9. Birthplace <u>Baltimore, Md.</u> (Town, county, and state)				DURATION <u>5 yrs.</u> <u>7 mos.</u> <u>3 yrs.</u>			
10. Usual occupation <u>carpenter</u>				Due to.....			
11. Industry or business				Other conditions.....			
FATHER		12. Name <u>Louis Phillip Jager</u>		(Include pregnancy within 3 months of death)			
MOTHER		13. Birthplace <u>md.</u>		Major findings of operations			
14. Maiden name <u>Margaret Schneider</u>		15. Birthplace <u>md.</u>		Date of op.			
16. Informant <u>Mr. Charles Jager</u>				Autopsy results			
Address <u>Summit Avenue, R.F.D. 6 Towson</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
17. Burial <u>12-22-47</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Holy Cross</u> Location <u>Brooklyn</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....			
18. Funeral director <u>Leonard J. Ruck</u>				23. SIGNATURE <u>A. M. Bacon M.D.</u> M. D. or other			
Address <u>5305 Harford Road, 14</u>				Address <u>2810 Taylor Ave.</u> Date signed <u>12/20/47</u>			
19. 12/20 1947 (Date rec'd by registrar)				Registrar <u>A. M. Bacon</u>			

RECEIVED

DEC 22 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information in full. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10936

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford
 City or town Abingdon
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mary Jarusek

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife Frank JarusekDeceased - 1940

6. (c) If alive, give age _____ years

T. Birth date of deceased (mo., day, yr.) April 21, 18708. AGE: Years Months Days If less than one day
77 8 0 _____ hrs. _____ min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Francis Goldschmidt13. Birthplace Baltimore, Md.14. Maiden name Catherine Steska15. Birthplace Bohemia16. Informant Hospital recordsAddress Catonsville, 28, Maryland17. Burial Date thereof Dec 24 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Oak HillLocation Golden Ring Bldg. Md18. Funeral director Howard K. McGowanAddress Abingdon Md19. 12/29 47 A. W. Tedrich
(Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21st 1947 at 6:35 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2nd 1947 to December 21st 1947 and that I last saw him er alive on December 21st 1947Immediate cause of death Chronic sclerotic coronary disease DURATION IndefiniteDue to Arteriosclerotic heart disease "Due to Generalized arteriosclerosis "

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results None held

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

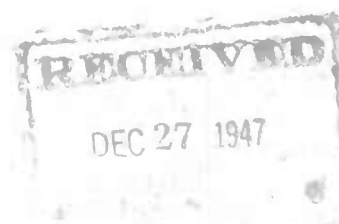
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk M.D. M. D. or otherAddress Catonsville, 28, Maryland Date signed 12/21/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10937 44

1. PLACE OF DEATH:

County Balto.City or town Sperrin Point Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10938

Reg. Dist. No. 40

1. PLACE OF DEATH:
County Baltimore
City or town Green Arm - Notch Cliff
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. Louison
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME Ernest Dyson Jones

3. (b) Social Security Number

4. Sex Male 5. Color or race Col 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) Oct 8, 1911 6. (c) If alive, give age years
8. AGE: Years 36 Months Days If less than one day hrs. min.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 19 47 at 7:50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him give on 19
Immediate cause of death Crushed chest and suffocation
accidental. DURATION 12/9/47
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

9. Birthplace Bald County Md
(Town, county, and state)
10. Usual occupation Labourer
11. Industry or business Schuman Construction Co
12. Name Joseph W. Jones
13. Birthplace Charles Co. Md.
14. Maiden name Elizabeth Dyson
15. Birthplace Charles Co Md.
16. Informant Joseph Jones
Address 1028 Stirling St.
17. Burial Date thereof Dec. 13/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location Bald Notch Cem
18. Funeral director Mrs Robt G. Elliott's Off
Address 1129 N. Caroline St
19. 12-12 19 47 D. W. Hedrich
(Date rec'd by registrar) Registrar

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
accident, suicide, or homicide over and over Date of 12/9/47
Where did injury occur? Green Arm Balto Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury over and over Injured at work? yes
23. SIGNATURE Rollin G. Hedrick M.D. D.M.E.
Address Thurston Md Date signed 12/9/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

10939

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:

County..... Baltimore

City or town..... Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Catonsville Convalescent Home

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... Baltimore

City or town..... Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 315 Inglewood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Georgena Jungers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife..... John Jungers

7. Birth date of deceased (mo., day, yr.) March 13, 1859

8. AGE:	Years	Months	Days	If less than one day
	88	8	21 hrs. min.

9. Birthplace..... London, England
(Town, county, and state)

10. Usual occupation..... None

11. Industry or business

12. Name..... Unknown

13. Birthplace..... Unknown

14. Maiden name..... Unknown

15. Birthplace..... Unknown

16. Informant..... Mrs. Lucian Brady

Address..... Annapolis, Md.

17. Burial Date thereof..... Dec. 6, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... St. Mary's Cemetery

Location..... Annapolis, Md.

18. Funeral director..... E.W. Jamoreau

Address..... 1003 W. Baltimore St.

19. 12/9 1947 A.W. Hedrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 4 1947 at 20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1 1946 to December 4 1947 and that I last saw her alive on December 4 1947

Immediate cause of death..... Cerebral Hemorrhage

Due to..... Cerebral Hemorrhage

Due to..... Cerebral Hemorrhage

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Address..... Ellicott City, Md.

Date signed..... 12/9/47

RECEIVED
DEC 9 1947
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10940

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
 County Baltimore County
 City or town Graceland Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
1805 Maxwell Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Baltimore
 City or town Graceland Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1805 Maxwell Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Eleanor Kaczorowski (Krantz)

3. (b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Joseph Kaczorowski
 7. Birth date of deceased (mo., day, yr.) 1865 6.(c) If alive, give age years
 8. AGE: Years 82 Months Days If less than one day hrs. min.

9. Birthplace Poland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
FATHER
 12. Name Peter Welnicki
 13. Birthplace Poland
MOTHER
 14. Maiden name unknown
 15. Birthplace Poland

16. Informant Peter Kaczorowski
 Address 1805 Maxwell Ave

17. BURIAL Date thereof 12/9/1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory HOLY ROSARY
 Location GERMAN HILL RD

18. Funeral director John M. Decker
 Address 401 W. Chester St.

19. 12/5 19 47 Quade Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 19 47 at M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 46 to Dec. 4 19 47
 and that I last saw him alive on Dec. 3 19 47
 Immediate cause of death Arterio-sclerosis DURATION 5 days
Ch. Nephritis & Hypertension
 Due to ?
Obstructive - Pleurisy
 Due to ?
 Other conditions Thrombosis of left femoral artery 2.405
 (Include pregnancy within 3 months of death)

Major findings of operations Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Quade Smith M. D. or other 12/5/47
 Address 200 W. E. Pratt St. Date signed 12/5/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Williams
2515 Taylor Avenue

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10941 38

1. PLACE OF DEATH:

County..... Parkville

City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7618 Daniels Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Parkville

City or town..... Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 7618 Daniels Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

FREDERICKA KANE

3. (b) Social Security Number

4. Sex..... female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... widowed

6.(b) Name of husband or wife..... William James Kane

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... May 24, 1875

8. AGE: Years..... 72 Months..... 6 Days..... 7 If less than one day..... hrs. min.

9. Birthplace..... Baltimore, Md.

(Town, county, and state)

10. Usual occupation..... at home

11. Industry or business

12. Name..... John Hoblitzel

13. Birthplace..... Germany

14. Maiden name..... ANNIE GINTER

15. Birthplace..... Md.

16. Informant..... Mr. Wm. W. Kane

Address..... 7618 Daniels Avenue, Parkville

17. Burial Date thereof..... 12-4-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Moreland Memorial Park

Location..... Maryland

18. Funeral director..... Leonard J. Ruck

Address..... 5305 Harford Road

19. 12/3/47
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 1st 19 47, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29 19 47 to Dec. 1 19 47.

and that I last saw her alive on Dec. 4, 1947 19 47.

Immediate cause of death.....

Chronic Myocarditis - years
and Acute Pulmonary Edema
Due to..... Hypertensive Cardiovascular
disorder with cardiac
hypertrophy, pulmonary
edema, congestion of right heart,
and peripheral edema

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE..... Robert C. Williams M.D.

M. D. or other

Address..... 2515 Taylor Ave. Date signed..... 12-2-47

Dec. 14, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10942

41

1. PLACE OF DEATH:

County BaltimoreCity or town D.O.A. VAH, Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Perryville
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war WW I

3. (a) FULL NAME

GARY KANE

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife Single7. Birth date of December 23, 1889
deceased (mo., day, yr.)

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

5804

hrs.

min.

9. Birthplace Perryville, Maryland
(Town, county, and state)10. Usual occupation unemployed

11. Industry or business

12. Name Thomas Kane13. Birthplace Ireland14. Maiden name Sarah McClentock15. Birthplace Perryville, Maryland16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof Dec 21, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Blight Funeral HomeAddress 4914 Belair Rd., Baltimore, Md.19. 12/28/47 W. Mearns
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1947 D.O.A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19____, to 19____

and that I last saw him alive on 19____

Immediate cause of death

ASTHMA

DURATION

4 yrs.

Due to _____

Due to _____

Other conditions Arteriosclerosis, generalized Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

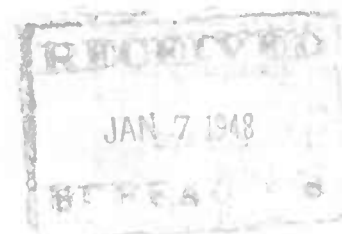
Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

W.M. CARMINE, M.D. DEPUTY MED. EX.Address Dundalk 22, Md.Date signed 12/27/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

County... Baltimore
 City or town... Fulton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 years
 Hospital, institution, or street address where death occurred:
3510 Paddy Hill Dr.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Md. County... Baltimore
 City or town... Fulton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3510 Paddy Hill Dr.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

George W. (mother) Kennady

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Annie H. Porter ~~Sullivan~~
(deceased)

7. Birth date of deceased (mo., day, yr.)

May 6, 1861

6. (c) If alive, give age, years

8. AGE:

Years

Months

Days

if less than one day

86

7

2

hrs.

min.

9. Birthplace

Franklin County Penn.
(Town, county, and state)

10. Usual occupation

Farmer, & laborer

11. Industry or business

MOTHER FATHER

12. Name

Lemuel Kennedy

13. Birthplace

unknown

14. Maiden name

Catherine Bender

15. Birthplace

18. Informant

Mrs. Mamm Kline

Address

3510 Paddy Hill

17. Burial (Burial, cremation, or removal, Which?)

Date thereof

12/11/47
(month) (day) (year)

Cemetery or crematory

Church of God Cemetery

Location

Plainfield Penna.

18. Funeral director

Lambert Funeral Home

Address

7701 Belair Rd.

19. Dec. 9 (Date rec'd by registrar)

19. 47

Mrs. J. T. Rybinski

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 8

19. 47

at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 5

19. 47

to Dec 8

19. 47

and that I last saw him alive on

Dec 8

19. 47

Immediate cause of death

Coronary Insufficiency

DURATION

5 days

Due to

arteriosclerosis

many yrs.

Due to

senility

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Max R. English M.D.

M. D. or other

Address

5713 Belair Rd.

Date signed

12-8-47

RECEIVED

DEC 10 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information as fully as possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10944 20

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville- 28, Maryland.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 months, eight days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 4 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Halethorpe
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1707 Sulphur Spring Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

KENNEDY, Harry E.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Amelia Oberdorffer
 6.(c) If alive, give age 55 years
 7. Birth date of deceased (mo., day, yr.) November 17, 1881 (?) 1882
 8. AGE: Years 65 ~~60~~ Months 00 Days 25 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland.
 (Town, county, and state)
 10. Usual occupation Machinist.
 11. Industry or business
 12. Name John T. Kennedy
 13. Birthplace Baltimore, Maryland.
 14. Maiden name Unknown.
 15. Birthplace Unknown.

16. Informant Hospital Records.
 Address Catonsville- 28, Maryland.
 17. Burial Date thereof 12/15/47.
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Parvine Ph.
 Location Woodlawn, Md.
 18. Funeral director Harry H. Nuttke
 Address 4101 E Edmondson Ave
 19. 12-15-47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 19 47 at 1:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4 19 47 to December 12 19 47
 and that I last saw him alive on December 12 19 47

Immediate cause of death.....
Coronary Sclerosis;
Chronic arteriosclerotic heart
 Due to disease:
Generalized arteriosclerosis.
 Due to.....

DURATION

Indef.Indef.Indef.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE Isadore Turk, M. D.
 M. D. or otherAddress Catonsville-28, Maryland Date signed 12-12-47.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

10945

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 98 days
 Hospital, institution, or street address where death occurred:
Veterans Administration Hospital
 How long in hospital or institution? 98 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore Co.
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6905 Marlborough Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war WW-I

3. (a) FULL NAME

CHARLES A. KING

3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced
Married Divorced
 6. (b) Name of husband or wife deceased Lillian
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) September 18, 1889
 8. AGE: Years 58 Months 3 Days 9 If less than one day
 hrs. min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation unemployed Fireman,
Railroad,
 11. Industry or business
 12. Name John King Alonzo Joseph King,
 13. Birthplace unknown Maryland
 14. Maiden name Edith Ada Virginia Reynolds,
 15. Birthplace Maryland

16. Informant Clinical Records, Veterans Adminis-
tration Hosp. Fort Howard, Md.
 Address

17. Burial Burial Date thereof 12/30/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Druid Ridge Cemetery
 Location Pikesville, Maryland

18. Funeral director Vernon C. Lemmon
 Address 4611 Park Heights Ave. Balto. Md.

19. Nov 29 1947 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 19 47 at 6:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 20 19 47 to Dec. 27 19 47
 and that I last saw him alive on December 27 19 47

Immediate cause of death
Disease of the Heart due to hyper- DURATION 2 yrs.
tension and arteriosclerosis plus
 Due to Hypertension, arterial, systemic 2 yrs plus
 Due to Arteriosclerosis, general 2 yrs. plus
Residuals of old rt. hemiplegia 2 yrs. plus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stalter R. Benson - M.D.
 M. D. or other
 Address V.A.H. Fort Howard, Md. Date signed 12-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (Indicate correct age especially important. Physicians: please write the causes of death clearly and legibly.)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10946

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltoCity or town Bundack 22
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md CountyCity or town Bundack 22
(If outside city or town limits, write RURAL and give nearest town)Street No. Wm Lane + Ford RE Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Gladys King

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 19-1940

8. AGE:

Years

Months

Days

If less than one day

7

hrs. min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

FATHER

12. Name

William King

13. Birthplace

Ga.

MOTHER

14. Maiden name

Gladys Beverly

15. Birthplace

va

16. Informant

Rev. David Banks

Address

1319 N. Caroline St. Balto

17. Serial

Serial

Date thereof

12-24-47
(month) (day) (year)

(Burial, cremation, or removal, Which?)

Cemetery or crematory

Mt Calvary C.

Location

Anne Arundel Co.

18. Funeral director

William A. Jackson

Address

915 Penna. Ave. Balto19. 2/23-47

(Date rec'd by registrar)

John G. Connelly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 19 47 at 500 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Shock

DURATION

Due to 3rd Burns / extensive rot

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11/23/47Where did injury occur? Mt. Dundas - Balto
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury House burned down Injured at work? No23. SIGNATURE W. A. JacksonAddress 915 Penna. Ave. Balto Date signed 11/24/47

RECEIVED

JAN 7 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10947

Reg. Dist. No. 44

1. PLACE OF DEATH

County BaltoCity or town Bundick 22
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Life

3. (a) FULL NAME

Thelma King

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug 29 - 1936

8. AGE:

Years

Months

Days

If less than one day

11

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

47

John B. Cunniff

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 22

19

47

at

500

A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw h.

alive on

19

Immediate cause of death

Shock -3rd° Burns - fracture body

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place, (where?)

Injured at work?

Means of injury

23. SIGNATURE

Address

Date signed

RECEIVED

JAN 7 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 180

10948

1. PLACE OF DEATH:

County BaltimoreCity or town Bundick 22
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County Bundick 22City or town Bundick 22
(If outside city or town limits, write RURAL and give nearest town)Street No. 3000 S. Ave. + North St. Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William King Jr.

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 2 - 1934

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

13

hrs.

min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

12-24-47
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

12-23-1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 - 1947 at 5:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 to 19

Immediate cause of death

Shock caused by 3rd degree Burns of entire body

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12/23/47Where did injury occur? That Bundick - Baltimore (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury House burned Injured at work?23. SIGNATURE M.B. Davis M.D. or otherAddress Bundick - VV - Date signed 12/24/47

RECEIVED

JAN 7 1948

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10949

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.
City or town Boring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.
City or town Boring
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Henry Frederick Koenig

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Fredia C. Koenig

6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 27, 1894

8. AGE: Years 53 Months 3 Days 4 If less than one day
hrs. min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual occupation Owner of Gasoline Station

11. Industry or business

12. Name John G. Koenig

13. Birthplace Germany

14. Maiden name Anna Schudel

15. Birthplace Germany

16. Informant E.G. Koenig

Address Reisterstown, Md.

17. Burial Date thereof Dec. 3, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Paul

Location Upperco, Md.

18. Funeral director J.F. Eline & Sons

Address Reisterstown, Md.

19. Dec-3- 19 47 Mary B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 19 47 at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-26 19 39, to 12-1 19 47
and that I last saw him alive on Nov 29 19 47

Immediate cause of death Carcinoma of Lung DURATION 1 yr.

Due to

Due to

Other conditions Diabetes 8 yrs
Red Eyes 5 yrs
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

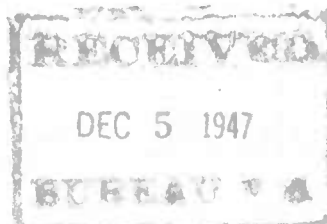
23. SIGNATURE D. D. Caplan, M.D. M. D. or other

Address Reisterstown, Md. Date signed 12-1-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Evidence for the change of date of death and

date of birth is shown on G 113 12/18/47

STATE OF MARYLAND—CERTIFICATE OF DEATH

10950

1. PLACE OF DEATH

County

Village or City

Baltimore
Hazelwood Park

No.

7104 Martell Ave

Registration Dist. No.

St.

Ward

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S. if of foreign birth?

yrs.

mos.

ds.

2. FULL NAME

(a) Residence No.

Josephine Elizabeth Kohl

St.

Ward.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)

Married

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

William T. Kohl

6. DATE OF BIRTH (month, day, and year)

April 17, 1876

7. AGE

Years

Months

Days

If LESS than

61

7

22

1 day, _____ hrs.
or _____ min.

OCCUPATION

8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.

Housewife

9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town)
(State or country)

Baltimore

FATHER

13. NAME

Wenceslaus J. Levy

14. BIRTHPLACE (city or town)
(State or country)

Bohemia

MOTHER

15. MAIDEN NAME

Antoinette

16. BIRTHPLACE (city or town)
(State or country)

Bohemia

17. INFORMANT

(Address)

William T. Kohl
7104 Martell Ave

18. BURIAL, CREMATION, OR REMOVAL

Place

Holy Redeemer

Date

12-13, 1947

19. UNDERTAKER

(Address)

Frank Brachman
900 N. Chester St

20. FILED

Dec 11-47 R. J. H. H. H.

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

Dec. 12, 9, 1947
(Month) (Day) (Year)

22.

I HEREBY CERTIFY, That I attended deceased from

DEC 10 9, 1947, to DEC 10 9, 1947

I last saw him alive on DEC 10 9, 1947; death is said

to have occurred on the date stated above, at 9:30 P.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:CEREBRAL HEMORRHAGE
HYPERTENSIVE C.V. DISEASEDate of onset
12/10/47
1947

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

NONE

Was there an autopsy? NO

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred IN INDUSTRY, IN HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

NO

If so, specify

(Signed)

Stephen C. Mockaitis

M. D.

(Address) 6714 Holabird Ave.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927
Other contributory causes of importance:	
Gallstones	May 1, 1923

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago
Other contributory causes of importance:	
Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

8/1/28

6714 Hoboken Ave

Dr. W. H. Harrison

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto.City or town Sparrow Point.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Dundalk.
(If outside city or town limits, write RURAL and give nearest town)Street No. Price Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married (separated)

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years 46Months 7Days 6

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Dec. 27-47
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 12/29/47

(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

217-014-143

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1947 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 25 1947 to Dec 25 1947and that I last saw him alive on Dec 25 1947

Immediate cause of death

Coronary aneurysm

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

D. or other

Date

DEC 29 1947

RECEIVED
DEC 29 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10952

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)Street No. 2802 Sparrows Pt. Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Michael P. Kondilar

3. (b) Social Security Number

213-07-4756

4. Sex

M

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

47

John J. Connelly

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11th 1947 at 8:40 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death

Coronary Occlusion 5 mi.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

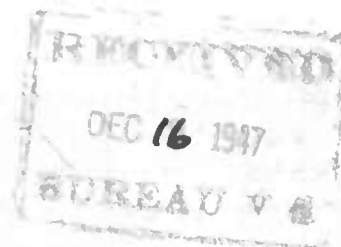
Injured at work?

23. SIGNATURE

W. B. Davis M.D.

Address

Date signed 12/1/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

1095338

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Balto Co
 City or town..... Rodgers Forge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 9 yrs
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... Balto
 City or town..... Rodgers Forge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 413 Murdoch Rd
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Edward Christian Routh

3.(b) Social Security Number

4. Sex..... M 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... Single
 B.(b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.)..... Sept 12 - 1876
 8. AGE: Years..... 71 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace..... Baltimore
 (Town, county, and state)
 10. Usual occupation..... Engineer
 11. Industry or business..... Retired
 12. Name..... Fleetwood C. Routh
 13. Birthplace..... Balto
 14. Maiden name..... Anna S. Aveser
 15. Birthplace..... Balto
 16. Informant..... Herbert L. Dempsey
 Address..... 413 Murdoch Rd
 17. Entombment Date thereof..... Dec 18 - 1947
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory..... Greenmount Cem
 Location..... City
 18. Funeral director..... Williot Funeral Home
 Address..... 2018 Pleasu St
 19. 12-18 19 47 Can't read
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Dec 14th 19 47 at 9:45 A.M.
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
Oct 27 19 47 to Dec 14 19 47
 and that I last saw him alive on Dec 14 19 47
 Immediate cause of death..... distention of heart
 Due to..... Hypertension, arteriosclerosis
 Due to..... Sclerosis
 Other conditions.....
 (Include pregnancy within 3 months of death)
 Major findings of operations..... Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?
 23. SIGNATURE..... Walter E. Knickman M.D.
 Address..... 225 Murdoch Rd
 Date signed..... 12/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10954

Reg. Dist. No. 43

1. PLACE OF DEATH:

 County Balto

 City or town Overlea
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

113 W. Elm Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

 State Md. County

 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)

 Street No. 113 W. Elm Ave
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Otto Paul Kuehnel

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single; married, widowed, or divorced

Married

6. (b) Name of husband or wife

Marie Antonie Kuehnel

7. Birth date of

deceased (mo., day, yr.)

Mar 20th 1881

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

66
9
5

hrs.

min.

9. Birthplace

Dresden, Germany
 (Town, county, and state)

10. Usual occupation

Accountant

11. Industry or business

Gustaf K. Kuehnel

12. Name

Dresden, Germany

13. Birthplace

Rosalie Holcim

14. Maiden name

Dresden, Germany

15. Birthplace

Walter Weber

16. Informant

113 Elm Ave. - Overlea

Address

 17. Burial
 (Burial, cremation, or removal. Which?)

Date thereof

12/29/47
 (month) (day) (year)

Cemetery or crematory

Parkwood

Location

Parkville, Md.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul St.

 19. 12/27/47 19

(Date rec'd by registrar)

A. H. Hedrick
per A. W. S.

Registrar

MEDICAL CERTIFICATION

 20. DATE OF DEATH Dec 25th 1947 at 3 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 3, 1947 to Dec. 25, 1947

 and that I last saw him alive on Dec. 24, 1947

Immediate cause of death

Toxic Abortion

DURATION

3 days

 Due to Carcinoma of stomach
3 1/2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury injured at work?

23. SIGNATURE

Michael J. Dausch M.D.

M. D. or other

 Address 1 W. Overlea Ave Date signed 12/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1095538

1. PLACE OF DEATH:

County Baltimore
 City or town Baysville Town +
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 1/2 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Baysville Town +
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1619 Natural Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Emma May Lancaster

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Leonard Lancaster
 7. Birth date of deceased (mo., day, yr.) May 4th 1891 6. (c) If alive, give age _____ years
 8. AGE: Years 56 Months 7 Days 25 If less than one day _____ hrs. _____ min.
 9. Birthplace Balto. Co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business At Home
 FATHER 12. Name Benjamin Bowen
 13. Birthplace Balto. Co. Md.
 MOTHER 14. Maiden name Jane Pinner
 15. Birthplace Balto. Co. Md.

16. Informant Ada Byrne
 Address 4305 Glenarm Ave. Balto. Co. Md.
 17. Burial Date thereof 1/1/48
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory Fork M. E.
 Location Balto. Co. Md.
 18. Funeral director William Cook, Inc.
 Address 1217 St. Paul St
 19. 12/20/47 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH December 29 1947 at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____ to _____ 19____
 and that I last saw _____ alive on _____ 19____

Immediate cause of death Heart disease, chronic
myocarditis & hypertension DURATION 3 yrs +

Due to _____

Due to _____

Other conditions Cerebral hemorrhage (left) 3 yrs
2 right hemiplegia
 (Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: _____

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Rollin C. Hudson MD. DMEAddress Towson Md M. D. or other _____Date signed 12/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

10956

472

1. PLACE OF DEATH:

County BaltimoreCity or town Catonville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Catonville
(If outside city or town limits, write RURAL and give nearest town)Street No. Frederick & Overbrook Rds.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

WALTER GRAHAM LANDON

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of ~~husband~~ or wife Louise H. (Schlosser)

7. Birth date of

deceased (mo., day, yr.)

Dec. 6, 1894

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

73-14

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Gracer

11. Industry or business

OWN BUSINESS

FATHER

12. Name Riley Landon13. Birthplace Md.

MOTHER

14. Maiden name Virginia Magruder15. Birthplace Md.16. Informant Mrs. Walter G. LandonAddress Frederick & Overbrook Rds.17. BURIAL
(Burial, cremation, or removal. Which?)Date thereof Dec. 22, 1947
(month) (day) (year)Cemetery or crematory Landon ParkLocation 3801 Frederick Rd.18. Funeral director Harry H. WightAddress 4101 Edmondson Ave19. 12/22 19 47 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 19 47 at 4:15 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
month 13 19 47 to December 20 19 47
and that I last saw him alive on December 19 19 47

Immediate cause of death

Carcinoma of left lung.

DURATION

10 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William K. Gallagher M.D.

M. D. or other

Address Catonville 6-28, Md. Date signed 12/21/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *10957*

1. PLACE OF DEATH

County *Baltimore*
City or town *Rural - Middle River*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *life*
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State *Maryland* County *Baltimore*
City or town *Rural*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *Bird River & Wampler Roads*
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Margaret Jennie Lauback

3. (b) Social Security Number

4. Sex *F* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *M*

6. (b) Name of husband or wife

George B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *July 7th, 1887*

8. AGE: Years *60* Months *5* Days *14* If less than one day hrs. min.

9. Birthplace *Baltimore*
(Town, county, and state)

10. Usual occupation *at home*

11. Industry or business

12. Name *John Fitch*
13. Birthplace *Baltimore County, Md.*

14. Maiden name *Sippel*
15. Birthplace *Baltimore County, Md.*

16. Informant *Mr. George Lauback*
Address *Bird River & Wampler Roads*

17. *burial* Date thereof *12/24/47*
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Parkwood*
Location *Baltimore, Md.*

18. Funeral director *Lauback Funeral Home*
Address *7401 Belair Road*

19. *12/23* 19*47* *Sam. Haluch*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *12/21* 19 *47* at *8:30 A* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Nov. 20* 19 *47*, to *Dec 21* 19 *47*
and that I last saw him alive on *12/20* 19 *47*

Immediate cause of death *Pneumonia* DURATION *3 days*

Due to *Bronchogenic Carcinoma*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *A. L. Kolodney MD*

Address *45 Edgewate Apts* M. D. or other *12/21/47*
Date signed

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10958

Reg. Dist. No. 43

1. PLACE OF DEATH:

County Ba to
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Ba to
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7419 Brookwood Rd
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

William M.

3. (b) Social Security Number

Lessner None

4. Sex

M.

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Elizabeth M.

7. Birth date of deceased (mo., day, yr.)

Oct 24 1869

8. (c) If alive, give age..... years

8. AGE:

78

Years

11

Months

7

Days

If less than one day

hrs.

min.

9. Birthplace

Ba to
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

Lessner

13. Birthplace

Ba to

MOTHER

14. Maiden name

Ba to

15. Birthplace

Ba to

16. Informant

Mary E. DeLuca

Address

7419 Brookwood Ave

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

12 4 47
(month) (day) (year)

Cemetery or crematory

Belair Rd

Location

4300 Belair Rd

18. Funeral director

Frantz H. E. Dippel

Address

7110 Belair Rd

19.

12/3

(Date rec'd by registrar)

47A. W. HedrickDr

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec 1 19 47 at 10:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 14 19 47 to Dec 1 19 47and that I last saw him alive on Nov 30 - 47 19 47

Immediate cause of death.....

Cerebral hemorrhage

Due to.....

arteriosclerosis

Due to.....

Other conditions.....

(Include pregnancy within 9 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... Alfred H. Hedrick MD

M. D. or other

Address 4416 Northern Parkway Date signed 12/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

0410959

Reg. Dist. No.

30

1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville 28, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 months 28 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 4 months 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore City CityCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 1302 W. Lexington Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

LEUTBECKER, ADA

3. (b) Social Security Number

4. Sex <u>F</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
--------------------	------------------------------	--

6.(b) Name of husband or wife ---7. Birth date of deceased (mo., day, yr.) 1854

8. AGE:	Years	Months	Days	If less than one day
	<u>93</u>	<u>0</u>	<u>23</u>	hrs. min.

9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Domestic12. Name John M. Leutbecker13. Birthplace Germany14. Maiden name Sarah Collista Garner15. Birthplace Virginia16. Informant Hospital RecordsAddress Catonsville 28, Maryland17. Burial Date thereof Dec. 31, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Landon ParkLocation Baltimore18. Funeral director Rita WiedefeldAddress 9006 Biddle St19. 12-30-47 A. W. Halberst
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1947 12 N. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31, 1947 to December 29, 1947and that I last saw her alive on December 29, 1947

Immediate cause of death

Cerebral accident

DURATION

2 1/2 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Fuhr M.D. M. D. or otherAddress Catonsville 28, Maryland Date signed 12/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

10960

1. PLACE OF DEATH:

County Baltimore Co.City or town Cokeville Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Days

Hospital, institution, or street address where death occurred:

Masonic Home, Cokeville Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Brooklyn New York County New YorkCity or town Brooklyn
(If outside city or town limits, write RURAL and give nearest town)Street No. 582 Pacific Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Miss Ida Lindemeyer4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

B. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Sept. 5 - 18568. AGE: Years 91 Months 3 Days - If less than one day _____ hrs. _____ min.9. Birthplace New York City
(Town, county, and state)10. Usual occupation Housekeeper

11. Industry or business

12. Name Phillip Lindemeyer Sr.13. Birthplace Germany14. Maiden name Anne Emily Herbert15. Birthplace New York City16. Informant Laura M. SchroederAddress Masonic Home, Cokeville, Md17. Burial Date thereof Dec 16 47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Palisades CemeteryLocation Union City N. J.18. Funeral director Wm. CookAddress St. Paul & Preston St19. L. M. Schroeder
(Date rec'd by registrar) 19 _____ Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 19 47, at 7 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 47, to Dec 13 19 47, and that I last saw her alive on Dec 13 19 47.

Immediate cause of death

DURATION

Due to Congestive Heart failure 3 daysDue to Generalized Arteriosclerosis 8 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE Walter J. Kupp M.D. M. D. or otherAddress Cokeville Md Date signed 12-13-47

RECEIVED
DEC 19 1947
BUREAU F.B.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10961

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 hrs. 25 mins.

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 10 hrs. 25 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 425 S. Gilmor Street

(If rural, give LOCATION)

2.(a) If veteran, name war WW ✓

3.(a) FULL NAME

JOHN H. MASINGO

3.(b) Social Security Number

217-05-14844. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single6.(b) Name of husband or wife —

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 30, 18908. AGE: Years 57 Months 10 Days 26 If less than one day
hrs. min.9. Birthplace Baltimore, Maryland
(Town, county, and state)10. Usual occupation Janitor

11. Industry or business

12. Name John H. Masingo13. Birthplace Maryland14. Maiden name Catherine Ruhl15. Birthplace Maryland16. Informant Clinical Records, Veterans Adminis-Address tration Hospital, Fort Howard, Md.17. Burial Date thereof Dec. 29, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Louisa ParkLocation 3801 Frederick Rd.18. Funeral director Harry H. Witzke Funeral Dir.Address 4101 Edmondson Ave. Baltimore, Md.19. 12-29-47 19 Q. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1947 at 2:25 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 25 1947 to December 26 1947
and that I last saw him alive on December 26 1947Immediate cause of death
LOBULAR PNEUMONIA DURATION
5 days approx.Due to PNEUMOCOCCUS

Due to

Other conditions BILATERAL INGUINAL HERNIA Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. A. Henders M. D. or otherAddress V.A.H. Fort Howard, Md. Date signed 12-26-47

1911

$$\begin{array}{r} 46 \\ 3 \\ \hline 138 \end{array}$$

#-1
8-6-18
1-2

$$\begin{array}{r} 830 \\ 194 \\ \hline 1024 \end{array}$$

$$\begin{array}{r} 138 \\ 4 \\ \hline 48 \\ 2 \\ \hline 192 \end{array}$$

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

178C

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County Balto.
City or town Essex 21
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

321 Homberg ave
How long in hospital or institution? 5 mo.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Same County SameCity or town Same
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Dorothy Marie McGainey

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

John Joseph

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 10/1925

8. AGE:

Years

Months

Days

If less than one day

22524

hrs.

min.

9. Birthplace

Baltimore
(Town, county, and state)

10. Usual occupation

Wife

11. Industry or business

Home

FATHER

12. Name

Chas. B. Myers

13. Birthplace

Baltimore

MOTHER

14. Maiden name

Dorothy

15. Birthplace

Balto. (Husband)

16. Informant

John Joseph McGainey

Address

321 Homberg ave Essex 21

17. Burial, cremation, or removal. Which?

Burial Date thereof Dec 8/47
(month) (day) (year)

Cemetery or crematory

Balto Cem

Location

Balto Md.

18. Funeral director

Philip Herwig Sons

Address

2024 Orleans St

19. Date rec'd by registrar

12/15 19 47 Awthorist Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1947 at 4 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....
and that I last saw him alive on 19.....

Immediate cause of death

Barbaric homicide poisoning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12/4/47Where did injury occur? Essex Balto. Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury overcome by untimely turner. yrs.

23. SIGNATURE

McLearnie H. S.Address Balto Co. Dundalk Date signed 12/4/47

Rec'd US
12/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10963

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County BaltimoreCity or town Bundalk
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

6908 Solleys Point Rd -

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Bundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 6908 Solleys Point Rd -

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Nesbitt Mc Gougle

3. (b) Social Security Number

211-03-2883

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Charlotte Mary Mc Gougle

7. Birth date of

deceased (mo., day, yr.)

17 April 18818. (c) If alive, give age 66 years

8. AGE:

Years

66

Months

8

Days

8

If less than one day

hrs.min.9. Birthplace Monongahela -

(Town, county, and state)

Pennsylvania

10. Usual occupation

Electrician

11. Industry or business

Electrical

FATHER

12. Name

James J. Mc Gougle

13. Birthplace

Pennsylvania

MOTHER

14. Maiden name

Margaret Jenkins

15. Birthplace

Pennsylvania

18. Informant

Mr. Wm E Mc Gougle (son)

Address

6908 Solleys Point Rd

17.

Removal

(Burial, cremation, or removal. Which?)

Date thereof

Dec. 26, 1947

(month) (day) (year)

Cemetery or crematory

Location

Carrolltown, Pennsylvania

18. Funeral director

Roland L. Fisher

Address

2112 Dundalk Ave.

19.

12/27/47

(Date rec'd by registrar)

McGougle

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

25 Dec.

19

47 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2

19

to

19

and that I last saw him alive on

25 Dec.

19

Immediate cause of death

Coronary occlusion

DURATION

momentary

Due to

Coronary arteriosclerosis2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Butt Acetate M.D.

M. D. or other

Address

8 Liberty ParkwayDate signed 25 Dec 47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PERMANENT CAUSE

DATE OF EXAMINATION

PLACE OF EXAMINATION

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

PLACE OF SIGNATURE

SIGNATURE OF REGISTRAR

DATE OF SIGNATURE

PLACE OF SIGNATURE

RECEIVED
JAN 7 1948

1948, JAN 7

Carroll, J. H.
1948, JAN 7
1948, JAN 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10964

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville- 28, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs. 2 mos. 22 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 23 yrs. 2 mos. 22 days

3. (a) FULL NAME

MERRYMAN, Anna Annie

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Sam M. Merryman (deceased)

7. Birth date of deceased (mo., day, yr.) September 22, 1860 6. (c) If alive, give age _____ years

8. AGE: Years 87 Months 2 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore County
 (Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business Home.

FATHER 12. Name William Hutchins
 13. Birthplace England

MOTHER 14. Maiden name Sarah Merryman
 15. Birthplace Maryland

16. Informant Hospital Records
 Address Catonsville- 28, Maryland

17. Burial Date thereof Dec. 19, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hereford Baptist
Parkton R.F. 10.
 Location

18. Funeral director London M. Brooks
Spaulz, Md.
 Address

19. 12/29 19 47 R.W. Hedrich
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Monkton
 (If outside city or town limits, write RURAL and give nearest town)

Street No. None
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1947 at 10:28 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 25, 1947 to December 17, 1947

and that I last saw him alive on December 17, 1947

Immediate cause of death Cachexia DURATION 2 weeks

Due to Hypertensive C-V-R disease with cardiac decompensation and fibrillation Indefinite

Due to Arteriosclerotic heart disease with myocardial infarction old and fresh with healing Indefinite

Other conditions Secondary carcinoma of the liver Indefinite
undetermined source

Major findings of operations _____ Date of op. _____

Autopsy results as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

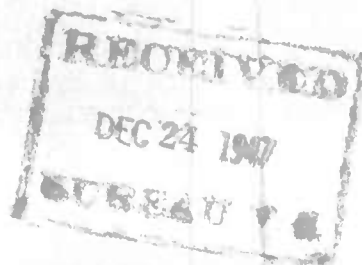
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M. D. M. D. or other _____

Address Catonsville-28, Maryland Date signed 12-17-47



CHO
COPY SENT TO LOCAL REGISTRAR No. _____ DATE 12/29/47

10-95. memorandum 56-20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10965

Reg. Dist. No. KK

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Maryland
 How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2234 W. Saratoga St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war WWI-Retired ✓

3. (a) FULL NAME

GEORGE MEYERS

3. (b) Social Security Number

217-05-4108

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Elizabeth Meyers
 7. Birth date of deceased (mo., day, yr.) 10-24-83 6. (c) If alive, give age 61 years
 8. AGE: Years 64 Months 1 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Alleghany, Pa.
 (Town, county, and state)
 10. Usual occupation Unemployed
 11. Industry or business _____

FATHER 12. Name Peter Meyers
 13. Birthplace Pittsburg, Pa.
 MOTHER 14. Maiden name Johanna Colhaus
 15. Birthplace Germany

16. Informant Clinical Records, Vets. Adm. Hosp.
 Address Fort Howard, Maryland

17. Burial Date thereof 12/10/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Baltimore National Cemetery
 Location Baltimore, Md.
Howard N. Blight Jr

18. Funeral director Howard Blight
 Address 4914 Belair Rd. Baltimore, Md.

19. 12/9 19 47 S.W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 19 47 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 1 19 47 to December 7 19 47
 and that I last saw him alive on December 7 19 47

Immediate cause of death Chronic Glomerulonephritis DURATION Unknown

Due to Unknown

Due to _____

Other conditions Cardiac Failure due to 10 Mos.
above. plus
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results Substantiated above.
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A.B. PUGH, M. D. M. D. or other _____Address V.A.H. Fort Howard, Md. Date signed 12-8-47

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

State of Maryland

CERTIFICATE OF DEATH

Registered No. 30

1. PLACE OF DEATH

(a) Baltimore City, Maryland

(b) Street address 13 Baumont Avenue

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED

(a) State Maryland (b) County Baltimore

(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)(d) Street No. 13 Baumont Avenue
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

MARY LOUISA MILLER

3 (b) If veteran, name war

NONE

3 (c) Social Security Account

No. NONE

4. Sex

Female

5. Color or race

White

6 (a) Single, married, widowed, or divorced.

Widowed

6 (b) Name of husband or wife Samuel H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March 24, 1877

8. AGE: Years Months Days If less than one day
70 8 20 hr. min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Benjamin F. Garrish

13. Birthplace Baltimore

14. Maiden Name Isabelle Ringrose

15. Birthplace Baltimore, Md.

16 (a) Informant Samuel H. Miller

(b) Address 13 Baumont Avenue, Catonsville

17 (a) Burial (b) Date thereof Dec. 17, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.

(b) Address 1217 St. Paul Street

19 (a) Dec 16, 47 (b) J. W. Hedrich
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14, 1947, at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12, 1946, to Dec. 14, 1947, and that I last saw him alive on Nov. 27, 1947.

Immediate cause of death

Coronary Thrombosis

Due to Atherosclerosis

Due to Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature

H. E. Reade

Address 1314-88 North Ave Date signed 12/17/47

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10968
Reg. Dist. No. 37

1. PLACE OF DEATH:

County.....*Baltimore*
City or town.....*Sparks, Rural*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....*Lifetime*
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State.....*Maryland* County.....*Baltimore*
City or town.....*Sparks (Rural)*
(If outside city or town limits, write RURAL and give nearest town)
Street No.....*York Rd.*
(If rural, give LOCATION)
2.(a) If veteran, name was.....

3. (a) FULL NAME

Mary Ellen Moals

3. (b) Social Security Number

none

4. Sex.....*F.* 5. Color or race.....*C.* 6. (a) Single, married, widowed, or divorced.....*married*

6. (b) Name of husband or wife.....*Maurice A Moals, Sr.*

6. (c) If alive, give age.....*?* years

7. Birth date of deceased (mo., day, yr.).....*July 15, 1863*

8. AGE: Year.....*84* Month.....*5* Day.....*—* If less than one day.....hrs.min.

9. Birthplace.....*Balto. Co., Md.*
(Town, county, and state)

10. Usual occupation.....*Domestic retired 25 yrs.*

11. Industry or business.....

FATHER 12. Name.....*John E. Moals*

13. Birthplace.....*Balto. Co., Md.*

MOTHER 14. Maiden name.....*Unknown*

15. Birthplace.....

16. Informant.....*Mrs. John Speed*

Address.....*Sparks, Maryland*

17. Burial, cremation, or removal, Which?.....*Burial* Date thereof.....*Dec. 19, 1947*
(month) (day) (year)

Cemetery or crematory.....*Shenandoah*

Location.....*Sparks, Balto. Co., Md.*

18. Funeral director.....*London M. Brooks*

Address.....*Sparks, Maryland*

19. Rec'd by registrar.....*rec'd 17* 19*47* *M. C. Evers* Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Dec. 15* 19*47* at.....*9:30* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....*Dec. 4* 19*47* to.....*Dec. 15* 19*47*

and that I last saw him.....*alive* on.....*Dec. 4* 19*47*

Immediate cause of death.....*chronic myocarditis*

Other conditions.....*hypertension*

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur?.....(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....Injured at work?

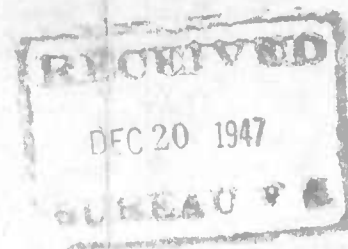
23. SIGNATURE.....*A. M. Francis* M. D. or other

Address.....*Parkton, Ind.* Date signed.....*12/16/47*

MARGIN RESERVED FOR BINDING

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information asked for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore-11
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3519 Roland Avenue
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

V.
Ella Mumma

3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Alfred Mumma
 7. Birth date of deceased (mo., day, yr.) May 26, 1886
 8. AGE: Years 61 Months 6 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Maryland
 (Town, county, and state)
 10. Usual occupation housewife
 11. Industry or business home

12. Name Walter Heffner
 13. Birthplace Baltimore
 14. Maiden name Emma Wilhelm
 15. Birthplace Maryland

16. Informant Hospital records
 Address Catonsville-28, Maryland

17. Burial Date thereof Dec. 16-1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Druid Ridge
 Location Pikesville, Maryland

18. Funeral director Burgee Funeral Home
 Address 3631 Falls Road, Baltimore

19. 12-10-47 Registrar [Signature]
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 19 47 at 7:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19 19 47 to December 14 19 47
 and that I last saw her alive on December 14 19 47

Immediate cause of death Cerebral hemorrhage DURATION 3 days

Due to Generalized arteriosclerotic cardiovascular disease indefinite

Due to Hypertensive cardiovascular disease "

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury Isadore Tuerk Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other _____

Address Catonsville-28, Md. Date signed 12-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County BaltoCity or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltoCity or town Balto
(If outside city or town limits, write RURAL and give nearest town)Street No. 2308 Evergreen Ave
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

William T. Newton

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Olevia W. Newton

7. Birth date of

deceased (mo., day, yr.)

Dec 17th 1864

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

8302

hrs.

min.

9. Birthplace

Balto. Md.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

MOTHER FATHER

12. Name

William T. Newton

13. Birthplace

Baltimore, Md.

14. Maiden name

Liza Jackson

15. Birthplace

Baltimore, Md.

16. Informant

Chas. T. Newton

Address

4116 Boorman Ave

17.

(Burial, cremation, or removal, which?)

Date thereof

12/22/47
(month) (day) (year)

Cemetery or crematory

Congressional

Location

Washington D.C.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul St.

19.

(Date rec'd by registrar)

Dec 20 19 47
Y. Keuffner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19th 19 47 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 10 19 47 to Dec 19 19 47and that I last saw him alive on Dec 19 19 47

Immediate cause of death

Chc. Myocard. Dis.

DURATION

2 monDue to Arterio SclerosisDue to Chronic BronchitisOther conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 12/20

RECEIVED

DEC 23 1947

SECRET

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10971

32

1. PLACE OF DEATH: County..... <u>Baltimore</u> City or town..... <u>Randallstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred: <u>Marriottsville Rd.</u> How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Maryland</u> County..... <u>Baltimore</u> City or town..... <u>Randallstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Marriottsville Rd.</u> (If rural, give LOCATION) 2. (a) If veteran, name war.....											
3. (a) FULL NAME <u>August Noderer</u>				3. (b) Social Security Number											
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Single</u>		MEDICAL CERTIFICATION									
8. AGE: <table border="1"> <tr> <td>Years</td> <td>Months</td> <td>Days</td> <td>It less than one day</td> </tr> <tr> <td><u>61</u></td> <td><u>7</u></td> <td><u>14</u></td> <td>..... hrs. min.</td> </tr> </table>				Years	Months	Days	It less than one day	<u>61</u>	<u>7</u>	<u>14</u> hrs. min.	20. DATE OF DEATH <u>December 12</u> 19 <u>47</u> , at <u>8:10A.</u> M. 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>12-12-'47</u> to <u>12-12-'47</u> and that I last saw him <u>alive</u> on <u>not seen alive</u> 19..... Immediate cause of death <u>Acute alcoholism</u> Due to Due to Other conditions (Include pregnancy within 3 months of death) Major findings of operations <u>NONE</u> Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.			
Years	Months	Days	It less than one day												
<u>61</u>	<u>7</u>	<u>14</u> hrs. min.												
9. Birthplace <u>Germany</u> (Town, county, and state) 10. Usual occupation <u>Farmer</u> 11. Industry or business				DURATION <u>1 wk.</u>											
12. Name <u>Joseph Noderer</u> 13. Birthplace <u>Germany</u> 14. Maiden name <u>Marie Fishhaber</u> 15. Birthplace <u>Germany</u>				22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....											
16. Informant <u>Otto Noderer</u> Address..... <u>2234 Wilkins Ave.</u> 17. Burial (Burial, cremation, or removal. Which?)..... Date thereof..... (month) (day) (year) Cemetery or crematory..... <u>New Cathedral</u> Location..... <u>4300 Frederick Road, Balto., Md.</u> <u>John J. Cowan & Son</u> 18. Funeral director Address..... <u>Poppleton & Hollins Sts.</u> <u>12 - 13 - 47</u> 19. (Date rec'd by registrar) <u>Dr. E. E. Nichols</u> Registrar				23. SIGNATURE <u>D.D. Caples, M.D. - Med. Exam.</u> M. D. or other Address..... <u>Reisterstown, Md.</u> Date signed..... <u>12-12-'47</u>											

CERTIFICATE OF DEATH

LOCAL HEALTH DEPARTMENT

STATE OF MASSACHUSETTS

LOCAL HEALTH DEPARTMENT

RECEIVED

DEC 15 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

10972

41

1. PLACE OF DEATH:

County Balto.City or town Drumkirk 22 Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

401 Hopkins Ct. (Solomon's Home)

How long in hospital or institution?

3. (a) FULL NAME

Mildred Annie Norfleet.

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

single.

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

811

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Date thereof

(month) (day) (year)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 6 1947 at 9 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....
and that I last saw him..... alive on..... 19.....

Immediate cause of death

DURATION

Bronchopneumonia

Due to

Due to

Other conditions

(2 1/2 lbs - 7 mos)

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. M. L. Williams, M.D.Address Balto. Co. Drumkirk 22 Md. Date signed 12/6/47

RECEIVED
JAN 7 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

10373

1. PLACE OF DEATH:
 County..... Parkville
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
3015 Willoughby Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Parkville
 City or town..... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3015 Willoughby Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Sophia Nyfeldt

3. (b) Social Security Number

4. Sex..... female 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... Nils M. Nyfeldt
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Aug. 27, 1871
 8. AGE: Years..... 76 Months..... 3 Days..... 24 If less than one day..... hrs. min.

9. Birthplace..... Baltimore, Md.
 (Town, county, and state)
at home

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... August Kochner
 13. Birthplace..... Germany

MOTHER 14. Maiden name..... Josephine Voytch
 15. Birthplace..... Germany

16. Informant..... Mr. Nils M. Nyfeldt
 Address..... 3015 Willoughby Avenue, 14

17. Burial..... 12024-47
 (Burial, cremation, or removal, Which?)..... (month) (day) (year)
 Cemetery or crematory..... Holy Redeemer
 Location..... Baltimore, Md.

18. Funeral director..... Leonard J. Ruck
 Address..... 5305 Harford Road, 14

19. 12/23 1947 A.W. Hedrick
 (Date rec'd by registrar)..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 21st, 47, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 1 1946 to Dec 21 1947
 and that I last saw him alive on Dec 13 1947

Immediate cause of death..... Acute Cardiac Dilatation
 DURATION..... 1947 Dec 21

Due to.....

Due to.....

Other conditions..... Chronic Hypertension 7 years

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE..... Morris B. Green M. D. or other.....Address..... 3009 E. Green Ave. Date signed..... 12/23/47Baltimore 14 Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10974 44
Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred:
408 E. Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md. County Baltimore
City or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. 408 E. Street
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Richard C. Oberdorf

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Bonita M. Oberdorf
7. Birth date of deceased (mo., day, yr.) March 11, 1916 6. (c) If alive, give age years
8. AGE: Years 31 Months 9 Days 2 It less than one day
hrs. min.

9. Birthplace Electrical Department
10. Usual occupation Riggs Dist. Co.
11. Industry or business Peter Calvin Oberdorf
12. Name Pennsylvania
13. Birthplace Helen
14. Maiden name Pennsylvania
15. Birthplace

16. Informant Mrs. Bonita M. Oberdorf
Address 408 E. Street, Sparrows Point
17. Burial Date thereof Dec. 16, 1947
(Burial, cremation, or removal, Which) (month) (day) (year)
Cemetery or crematory Oaklawn
Location Eastern Ave.
18. Funeral director Roland L. Fisher
Address 2112 Dundalk Ave.
Dec 15 - 47 D. T. Harber
19. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13, 1947 at 3 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947 to Dec 13, 1947
and that I last saw him alive on Dec 12, 1947
Immediate cause of death Cardio-respiratory Failure DURATION 24 hrs
Due to In anoxia 1 m 00
Generalized Carcinomatosis
Primary Carcinoma of Stomach 4 m 00
Other conditions pylorus of stomach
(Include pregnancy within 9 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Dwain L. Harber M. D. or other
Sparrows Point Md Date signed 12/15/47

MARGIN RESERVED FOR BINDING

VS A16 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

914 D 18

1947

RECEIVED
JAN 3 1948

RECEIVED
JAN 3 1948

JAN 3 1948

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RECEIVED
DEC 18 1947
BUREAU

RECEIVED

RECEIVED

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County BaltimoreCity or town Holbrook
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County BaltimoreCity or town Holbrook
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Mary Julia O'Leell

3. (b) Social Security Number

4. Sex F5. Color or race White6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Arthur E. O'Leell

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 1-12-18758. AGE: Years 72 Months 11 Days 9 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore, Co.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Daniel Lutch13. Birthplace Balto, Co.14. Maiden name Annie Reddish15. Birthplace Eastern Shore, Md.16. Informant Halma O'LeellAddress Holbrook17. Buried Date thereof Dec 24th
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Woods ChapelLocation Holbrook Maryland18. Funeral director C. Harry WarrAddress Seafordville Maryland19. 12/21/47 Tom. E. Martin
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1947 at 10:00 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 21 1947 to Dec. 21 1947and that I last saw her alive on Dec 21 1947Immediate cause of death Cerebral hemorrhage

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE Tom. E. Martin M. D. or otherAddress Randallstown Date signed 12/21/47

RECEIVED

FEB 2 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information you may have. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County... Baltimore
 City or town... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year, 1 month, 28 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 1 year, 1 month, 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County.....
 City or town... Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1616 West Fayette Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Marie Orman

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife John Orman
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) March 14, 1911
 8. AGE: Years Months Days If less than one day
36 9 3 hrs. min.

9. Birthplace West Virginia
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Home
 12. Name James Charles Moore
 13. Birthplace Virginia
 14. Maiden name Mary Isabelle Carver
 15. Birthplace Virginia

16. Informant Hospital records
 Address Catonsville-28, Maryland
 17. Burial- 2-13-48 Date thereof (month) (day) (year)
 (Burial, cremation, or removal. Which?)
 Cemetery or crematory Spring Grove State Hospital
 Location Catonsville 28, Md.

18. Funeral director Spring Grove State Hospital
 Address Catonsville 28, Md.

19. 2-13 19 48 VE Harry
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 19 47 at 3:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 19 19 46 to December 17 19 47
 and that I last saw her alive on December 17 19 47

Immediate cause of death Cachexia DURATION 4 mos.

Due to Carcinoma of the urethra
with extension by continuity indefinite

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Catonsville-28, Md. Date signed 12-17-47

RECEIVED

FEB 17 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10975

Reg. Dist. No. 9

1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Feb 18, 1946

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.How long in hospital or institution? Since Feb 18, 1946

3. (a) FULL NAME

Albert Pawlak

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Bertine Pawlak6. (c) If alive, give age 48 years7. Birth date of deceased (mo., day, yr.) April 1, 19008. AGE: Years 47 Months 8 Days If less than one day

hrs. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Rail Car Operator

11. Industry or business

12. Name John Pawlak13. Birthplace Germany14. Maiden name Mary Salsak15. Birthplace Germany

Personal History - Hospital Records

16. Informant

Address Eudowood Sanatorium, Towson 4, Md.17. Burial Date thereof 12/15/47

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. StanislausLocation Mt. Carmel Road16. Funeral director M. F. DubowichAddress 1808 Eastern Ave19. 12-12 1947 A. W. Hedrick

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore CityCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7736 E. Ruston St

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 1947 at 10:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 18 1946 to December 10 1947and that I last saw him alive on December 10 1947

Immediate cause of death

DURATION

Pulmonary tuberculosis SinceDue to December1945

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. F. Bridges M. D. or otherAddress Towson 4, Md. Date signed 12-10-47

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

10976

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH:

County Baltimore
 City or town Rural - Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 26 years
 Hospital, institution, or street address where death occurred:
Box 81, West Jurni River Beach Chase Md
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Rural - Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Box 81, West Jurni River Beach Chase Maryland
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Annie Gertrude Peacock

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Wesley Lindsay Peacock

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 21, 1878

8. AGE:

Years

Months

Days

If less than one day

6927

hrs.

min.

9. Birthplace Southport Brunswick, North Carolina
(Town, county, and state)10. Usual occupation Home

11. Industry or business

12. Name Charles Krew13. Birthplace Southport North Carolina14. Maiden name Mary Westcott15. Birthplace Southport North Carolina16. Informant Annie Gertrude PeacockAddress Box 81, Chase, Maryland17. Burial Date thereof Dec 31/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Woodlawn CemLocation Balto Co Md18. Funeral director Welsh Funeral HomeAddress 2008 Orleans St19. Dec 30 19 47 G.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1947 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 26 19 47 to Dec 28 19 47and that I last saw him er alive on December 27 19 47

Immediate cause of death

Coronary Occlusion

DURATION

Due to Hypertension and
arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Irving K. Beck, MD M. D. or otherAddress 30 Chandelle Rd Date signed Dec. 29, 1947Baltimore 20 MD

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH 176

Registered No. 44

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Ind (b) County 10977

(c) City or town Heliopolis
(If outside city or town limits, write RURAL and give town)(d) Street No. Box 85
(If rural give location)(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME

EUGENE

PEARSON

3 (b) If veteran, name war

3 (c) Social Security Account

No. 9

4. Sex

Male

5. Color or race

Colored

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

Dorothy Pearson

6 (c) If alive, give age 18 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

23

Months

10

Days

25

If less than one day

hr. min.

9. Birthplace

Huntington

(Town, county, and state)

10. Usual Occupation

Law firm worker

11. Industry or business

12. Name

Eugene Pearson

13. Birthplace

Tenn. (McMoresville)

14. Maiden Name

Dora Hunt

15. Birthplace

Tenn. (McMoresville)

16 (a) Informant

(b) Address

17 (a)

Burial

(b) Date thereof

Dec 25/45

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Cemetery

Location

Cambridge Mass

18 (a) Funeral director

Lewis H. Bayne

(b) Address

Cambridge Mass

19 (a)

12/16/45

(b)

A. W. Hedrick

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1947, at 6:15 M

21. I certify that I took charge of the remains described above, held an

Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry

by said Autopsy, Inspection or Inquiry, find that said deceased came

to his death on the day stated above, and death in my

opinion resulted from: natural causes ☐, accident ☒, suicide ☐.homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Pulmonary embolism

Acute dilatation of rt. ventricle of heart

Due to Left femoral thrombosis

Other Conditions. Fracture thoracic spine

Compression of spinal cord

(Include pregnancy within 3 months of death)

Decubitus ulcers

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:

(a) Date of injury 11/3/47 at about 10 a. M.

(b) Where did injury occur? Cambridge, Mass

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial

While at work? Yes

(d) Means of injury Struck by log - transferred

23. Signature H. G. Merrill M.D.

Date signed 12/16/47 Medical Examiner.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10978

Reg. Dist. No.

44

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Middle River, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 8 1/2 years
 Hospital, institution, or street address where death occurred:
1004 Wilson Pt. Rd.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore
 City or town..... Middle River, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1004 Wilson Point Rd., Apt. B
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

JOHN PIRIE

3. (b) Social Security Number

214-09-7451

4. Sex..... male 5. Color of face..... white 6.(a) Single, married, widowed, or divorced..... married
 6.(b) Name of husband or wife..... Hannah M. Pirie
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... January 21st, 1890
 8. AGE: Years..... 57 Months..... 11 Days..... 8 If less than one day..... hrs. min.

9. Birthplace..... Scotland
 (Town, county, and state)
 10. Usual occupation..... Engineer
 11. Industry or business..... G.L. Martin Co.,
 FATHER
 12. Name..... John Pirie
 13. Birthplace..... Scotland
 MOTHER
 14. Maiden name..... Elizabeth Fairgrave
 15. Birthplace..... Scotland

16. Informant..... Mrs. John Pirie
 Address..... 1004 Wilson Point Rd., Apt. B

17. burial Date thereof..... Jan 2 48
 (Burial, cremation, or removal Which?) (month) (day) (year)
 Cemetery or crematory..... Lawnview Cemetery
 Location..... Cleveland Ohio
Lassahn Funeral Home
 18. Funeral director.....
 Address..... 7401 Belair Rd.

19. 12/30/47 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... December 29 1947, at 12:10 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 - 20 1947 to 12 - 29 1947 and that I last saw him 1 M. alive on December 27 1947
 Immediate cause of death..... CORONARY Occlusion, Acute
 DURATION
 Due to..... Hypertensive CARDIO-VASCULAR Disease
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations.....
 Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of ..
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) ..
 Means of injury..... Injured at work?

23. SIGNATURE..... Joseph P. Leckman, M.D. M. D. of other
 Address..... 1006 Wilson Pt Rd Date signed..... Dec 29 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10979 44

1. PLACE OF DEATH:

County Baltimore CountyCity or town Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

George Washington Pitts

3. (b) Social Security Number

717-07-5448

4. Sex

M

5. Color of race

Col

6.(a) Single, married, widowed, or divorced

Widower

6.(b) Name of husband or wife

Carnie Pitts

7. Birth date of deceased (mo., day, yr.)

December 8th, 1877

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

7018

_____.hrs. _____.min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Rail road track man

11. Industry or business

Labor

MOTHER FATHER

12. Name

George Pitts Sr.

13. Birthplace

Maryland

14. Maiden name

unknown

15. Birthplace

16. Informant

Address

Clara Pitts
Chase, Md

17. (Burial, cremation, or removal. Which?)

Date thereof

Dec 29, 1947
(month) (day) (year)

Cemetery or crematory

Sharp Street Cemetery

Location

Chase, Md

18. Funeral director

Address

Mrs Pitts & Relatives
1129 N. Charles St19. 12-28-47 19_____
(Date rec'd by registrar)John B. Connelly
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26th 1947, at 3:30 P.M.21. I CERTIFY that death occurred on the 26th above stated; that I attended deceased fromDecember 11th 1947 to December 26th 1947and that I last saw him alive on December 25th 1947

Immediate cause of death

Cerebral apoplexy

DURATION

10 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____

Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

J. H. Thomas M.D.
Address Turner's Sta Date signed 12/27/47

RECEIVED

JAN 7 1948

RECEIVED

ARTICLE IN LEADER

STILLING CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

10980

1. PLACE OF DEATH:

County Baltimore DUNDALKCity or town DUNDALK
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County BaltimoreCity or town DUNDALK
(If outside city or town limits, write RURAL and give nearest town)Street No. 1748 Stengel Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Stanley Podsiadlo

3. (b) Social Security Number

none

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

marriedB. (b) Name of husband or wife Stella7. Birth date of deceased (mo., day, yr.) May 3, 18806. (c) If alive, give age 63 years8. AGE: Years 67 Months 1 Days 1 If less than one day
.....hrs.min.9. Birthplace Poland
(Town, county, and state)10. Usual occupation shoe-repairer

11. Industry or business

12. Name John Podsiadlo13. Birthplace Poland14. Maiden name Anna15. Birthplace Poland16. Informant Stella PodsiadloAddress 1748 Stengel Ave.17. Burial Date thereof 12/27/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy CrossLocation German Hill Rd.18. Funeral director M. W. F. Dippel's SonsAddress Lombard & 4th St.19. 12/26 19 47 L. W. Seidich
(Date rec'd by registrar) as Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1947 at 4:23 P. M.21. CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 20 19 47 to Dec. 23 19 47
and that I last saw him alive on Dec. 23 19 47Immediate cause of death coronary thrombosis
Myocardial Failure DURATION 1 dayDue to arteriosclerosis 4 daysDue to Coronary Artery Disease 4 daysOther conditions Lobar Pneumonia 4 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Leo J. Kulacki M.D. or otherAddress 126 S. Patterson Ave. Date signed Dec 24, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10981

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore

City or town Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo 11 days

Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Maryland

How long in hospital or institution? 2 mo 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 326 N. Euter St
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME

Wong Poo

3. (b) Social Security Number

4. Sex M 5. Color or race Y 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Dec 8 1902 8. (c) If alive, give age 47 years

8. AGE: Years 45 Months 0 Days 2 It less than one day hrs. min.

9. Birthplace China
(Town, county, and state)

10. Usual occupation Laundryman

11. Industry or business

12. Name Wong Poo

13. Birthplace San Francisco, Cal

14. Maiden name Chen Shee

15. Birthplace China

Personal History - Hospital Records

16. Informant Eudowood Sanatorium, Towson 4, Md.

Address

17. Burial Date thereof Dec 12/47
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Lorraine

Location Woodlawn, Ind.

18. Funeral director Stewart & Mowen Co.

Address 108 W. North Ave, City #1

19. Dec 11 19 47 A. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 19 47 at 120P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 19 47 to Dec 10 19 47

and that I last saw him alive on Dec 10 19 47

Immediate cause of death Pulmonary Tuberculosis

DURATION

9 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. W. Bridges M. D. or other

Address Towson 4, Md. Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 880 10982
 Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
 City or town Mt. Wittondale
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Baltimore
 City or town Mt. Wittondale
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 516 Sussey Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William A. Prince

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced
 6.(b) Name of husband or wife Emma I Prince
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 26 1869
 8. AGE: Years 78 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore Co Md
 (Town, county, and state)

10. Usual occupation Retired by State

11. Industry or business

MOTHER FATHER
 12. Name John Prince
 13. Birthplace England
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Emma I Prince
 Address 516 Sussey Road Mttondale

17. Burial Date thereof Dec 10 1947
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. John's Bur. Society
 Location Old York Road & 31st St

18. Funeral director John C. Moran
 Address 3000 E Baltimore St

19. 12/9 1947 A. W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1947 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4 1947 to Dec 7 1947 and that I last saw him alive on Dec 7 1947

Immediate cause of death Cerebral Hemorrhage
arterial hypertension

Due to arterio-sclerosis

Due to _____

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Louis R. Krumm M. D. or other
 Address 222 N. Kenwood Ave Date signed 12/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville-8
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Smith Avenue extended

How long in hospital or institution?

3. (a) FULL NAME

A
Harry Reynolds

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mahek Beard

7. Birth date of deceased (mo., day, yr.)

Nov. 21, 1875

8. AGE: Years Months Days It less than one day

77 0 12 hrs.

9. Birthplace

Phubing, Ohio
(Town, county, and state)

10. Usual occupation

Salesman

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Dec. 6, 1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Pikesville-8

(If outside city or town limits, write RURAL and give nearest town)

Street No. Smith Avenue, extended

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1947, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-3-1947 to 12-3-1947and that I last saw him alive on not seen alive

Immediate cause of death

Coronary Occlusion

DURATION

10 mins.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

NONE Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statitically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Where did injury occur? NONE

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. D. D. Exles

M. D. or other

Address Reisterstown, Md.Date signed 12-4-1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Balto.City or town Towson 1834 Loch Shiel Rd.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

EDGAR C. RICHARDS

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Nellie V. Richards7. Birth date of deceased (mo., day, yr.) July 24, 1879

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
68 5 2 .hra. min.9. Birthplace Balto. Md.
(Town, county, and state)10. Usual occupation Estimator11. Industry or business Dolphin Radiator & Fender Co.12. Name Louis Richards13. Birthplace Warsaw, Va.14. Maiden name Louisa Cromwell15. Birthplace A. A. Co. Md.16. Informant Mr. Carey NugentAddress 1834 Loch Shiel Rd. Towson 417. Burial Date thereof 12/30/47
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery Woodlawn Cem.Location Woodlawn, Md.18. Funeral director WM. J. TICKNER & SONS INC.Address North & Pa. Aves. Balto. 17, Md.19. Dec 29 19 47 G. W. Wilkins
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Towson 1834 Loch Shiel Rd.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

?

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 19 47 at 9:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 24 19 47 to Dec. 26 19 47
and that I last saw him alive on 12/26/47 19

Immediate cause of death

DURATION

Due to Coronary occlusion 2 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Benjamin Miller MD M. D. or otherAddress 2030 Wilkins Ave Date signed 12/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10986

1. PLACE OF DEATH:

County Balto
City or town Middle River P. D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
704 Middle River Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Maudie Richardson

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife John 6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 64 Months 06 Days 29 If less than one day..... hrs. min.

9. Birthplace.....
(Town, county, and state)

10. Usual occupation..... House wife

11. Industry or business

12. Name Lewis Absher

13. Birthplace N. C.

14. Maiden name Leffler

15. Birthplace N. C.

16. Informant Dora Green

Address 704 Middle River Rd

17. Buried Date thereof 12 5 47
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mt Carmel

Location Allegany Co N. C.

18. Funeral director W. Brydson

Address 457 Eastern Ave Rd

19. Dec. 3 47 John B. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2/47 19..... at 10

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19....., to..... 19.....
and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Cerebral accident

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. Carmine M.D.
Deputy Medical Officer

Address Baltimore Md Date signed 12/2/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 9 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93 d

10987

Reg. Dist. No. 37

1. PLACE OF DEATH:

County Baltimore
 City or town Cockeysville Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
Maroon Home Cockeysville Md
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1324 Canton Pl.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs Gertrude Simpson Ridgely

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Joshua T. Ridgely
 7. Birth date of deceased (mo., day, yr.) Dec 27th 1875 6.(c) If alive, give age _____ years
 8. AGE: Years 71 Months 11 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore
 (Town, county, and state)

10. Usual occupation None

11. Industry or business _____

FATHER 12. Name Reason Benjamin Simpson
 13. Birthplace Howard Co

MOTHER 14. Maiden name Elizabeth Mack
 15. Birthplace Baltimore

16. Informant Laura M. Schneider
 Address Maroon Home, Cockeysville Md

17. Burial Date thereof 12-23-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory David Ridge Cemetery
 Location Baltimore

18. Funeral director Wm. Cook
 Address St. Paul & Preston St

19. 12-19-47 19 _____
 (Date rec'd by registrar) Registrar Laura M. Schneider

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 19 47, at 5:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 29th 19 47 to Dec 19 19 47
 and that I last saw her alive on Dec 19 19 47

Immediate cause of death Acute congestion heart failure

Due to Arteria Sclerosis

Due to _____

Other conditions Cerebral Arteria Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

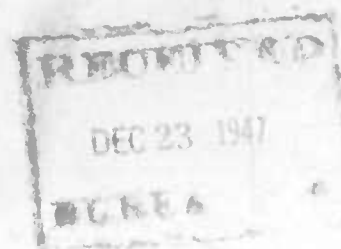
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Walter J. Kuss MD M. D. or other _____
 Address Cockeysville Md Date signed 12-19-47

41071



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10988

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Edgemere
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto.City or town Edgemere
(If outside city or town limits, write RURAL and give nearest town)Street No. 2822 Lodge Farm Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Herbert Jefferson Roberts

3. (b) Social Security Number

4. Sex

M.

5. Color or race

C.

6. (a) Single, married, widowed, or divorced

M.6. (b) Name of husband or wife Annesie Roberts

7. Birth date of deceased (mo., day, yr.)

Feb. 281879

6. (c) If alive, give age years

8. AGE:

88915

hrs. min.

9. Birthplace Brunswick Co. Va.
(Town, county, and state)

10. Usual occupation

Barber

11. Industry or business

FATHER

12. Name

Herbert Roberts

13. Birthplace

Va.

MOTHER

14. Maiden name

Panthenia Edmonds

15. Birthplace

Va.

16. Informant

Annesie Roberts

Address

2822 Lodge Farm Rd.

17.

(Burial, cremation, or removal. Which?)

Date thereof

12-16-47
(month) (day) (year)

Cemetery or crematory

Mt. Calvary

Location

R. A. Co.

18. Funeral director

Samuel W. Sullivan Jr.

Address

1011 N. Calington Ave

19.

12-15
(Date rec'd by registrar)

19

47A.W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 19 47 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1930 to Dec 12 19 47and that I last saw him alive on Dec. 12 1947

Immediate cause of death

Myocardial failure

Due to

Generalized arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Louis W. Sullivan M.D.

Address

6908 North Point Rd. Balto.

M.D. or other

Date signed

12/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County BaltimoreCity or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Ridge Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)Street No. Ridge Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Fannie Sauter

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

May 24, 1885

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

62610

.....hrs.

.....min.

9. Birthplace

Baltimore County, Md.
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER
MOTHER

12. Name

Christian E. Sauter

13. Birthplace

Baltimore County, Md.

14. Maiden name

Georgianna Powell

15. Birthplace

Virginia

16. Informant

Mr. C. Ellsworth Sauter

Address

Ridge Road, Woodlawn

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof Dec. 6, 1947
(month) (day) (year)

Cemetery or crematory

Mt. Olive Cemetery

Location

Pandallstown, Md.

18. Funeral director

Address

4510 Liberty Heights Ave.

19.

(Date rec'd by registrar)

19 47Tom E. Martin
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 19 47, at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 1, 1947 to Dec. 4, 1947
and that I last saw him alive on Dec. 4, 1947

Immediate cause of death

Cerebral hemorrhage

DURATION

1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Tom E. Martin

M. D. or other

Address

Harrisonville, Md.Date signed 12/4/47

RECORDED

DEC 22 1947

BUREAU FILE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 3/

10990

98d

1. PLACE OF DEATH:

County BaltimoreCity or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Old Court Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)Street No. Old Court Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Elizabeth Schildwatchter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Widowed</u>

6.(b) Name of husband or wife Henry Schildwatchter7. Birth date of deceased (mo., day, yr.) April 10, 1861

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>7</u>	<u>19</u>hrs.min.

9. Birthplace Germany
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Juergen Peters13. Birthplace Germany14. Maiden name Miss Martin15. Birthplace Germany18. Informant Mrs. Austin Wideman
Old Court Rd., Pikesville P.O., Md.
Address17. Burial Date thereof Dec. 2, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon Park CemeteryLocation Baltimore, Md.18. Funeral Director Wills LamoreauAddress 4510 Liberty Heights Ave.19. 11/29/47 W.E. Martin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1947 at 11.50P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 to 11/29/1947
and that I last saw h. er alive on Nov. 29, 1947

Immediate cause of death

DURATION

Cardio Vascular Disease

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.E. Martin M. D. or otherAddress Harrisonville, Md. Date signed 11/29/47

RECEIVED

DEC 22 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10391

1. PLACE OF DEATH:

County 2927 Ohio Ave
Baltimore Highlands
 City or town (If outside city or town limits, write RURAL and give nearest town)
15 Yrs.
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County
 City or town Baltimore Highlands
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2927 Ohio Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Giuseppe Serra

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife late Tersilia Serra
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb. 28 1867

8. AGE: Years 80 Months 10 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Decimo Bologna (Italy)
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Paolo Serra
 13. Birthplace Italy

MOTHER 14. Maiden name Silveria
 15. Birthplace Italy

16. Informant Emma Nicolai (Daughter)
 Address 2927 Ohio Ave (Baltimore Highland Md.)

17. Burial Jan. 3rd 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Holy Redeemer
Belair Rd. Baltimore Md.
 Location

18. Funeral director Frank Della Rose
 Address 52 N. Morley St.

19. 1/2 45 A.W. Hedrick
 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31, 1947 at 3 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1947 to Dec 31 1947
 and that I last saw him alive on Dec 30 1947

Immediate cause of death _____ DURATION

Cerebral Thrombosis 1 week
 Due to _____

Due to arteriosclerosis C.V.D.

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Paul Schuffel M. D. or other
 Address 2901 Carnegie St. Date signed 1/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH:

County... Balto
 City or town... Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 19 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME EVALYNN

Evalynn M. Severson

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Stephen W. Severson

6. (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) July 19, 1861

8. AGE: Years 66 Months 4 Days 27 If less than one day hrs. min.

9. Birthplace Baltimore Md
 (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

12. Name David F. Orr

13. Birthplace Nova Scotia

14. Maiden name Evalynn Mc. Spowan

15. Birthplace Pd

16. Informant Stephen W. Severson

Address 602 Orpington Road

17. Burial (Date thereof Dec 19, 1947)
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Landon Park

Location 3801 Frederick Ave

18. Funeral director Rev. Mrs. John R. Templeton

Address 5311 Edmondson Ave

19. Dec 18, 1947 A. W. Hedrich
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 602 Orpington Road
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 19 47 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 19 47 to December 19 47

and that I last saw her alive on December 19 47

Immediate cause of death Probably a gastrointestinal carcinoma. Patient has been

crippled for years with rheumatoid

arthritis and totally incapacitated. She has had a progressive

wasting, loss of weight, and

anemia. During the past year

with symptoms suggestive of an upper

gastrointestinal tract lesion. Due

to her poor condition studies could not

Major findings of operations be made.

No operation. Date of op. None.

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None. Date of None.

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury None. Injured at work?

23. SIGNATURE Phyllis (Fagen) J. M. D. brother

Address 11 E. Chase St. Balto. 2, Md. Date signed 12.18.47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10993

Reg. Dist. No. 42

1. PLACE OF DEATH:

County BaltimoreCity or town 3447 Maple - Oak Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Oak Park 3447 Maple

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1935 Belle Ave

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Louise E. Seymour

3. (b) Social Security Number

602-06-454. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Henry H. Seymour6. (c) If alive, give age 82 years7. Birth date of deceased (mo., day, yr.) Feb. 27-18798. AGE: Years 68 Months 9 Days 15 If less than one day _____ hrs. _____ min.9. Birthplace Baltimore County

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business at home12. Name Martin Selway13. Birthplace Germany14. Maiden name Anna E. Weaver15. Birthplace Germany16. Informant Martin H. SeymourAddress 1935 Belle Ave - Oak Park17. burial Date thereof Dec. 17-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory New BethlehemLocation Baltimore Md18. Funeral director F. B. Wicket & SonAddress 1300 E. Pratt Place19. 12-15-47 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17/47 at 8:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 1947, to Dec. 12 1947and that I last saw h. er alive on December 10 1947Immediate cause of death starvation audiusDue to senile dementia

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Nathan Racusin

M. D. or other

Address 206 S. Gilmer St. Date signed 12.13.47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10994

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Balto.
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Daughters of Eucharist

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

Civil War

2.(a) If veteran, name war _____

3. (a) FULL NAME

MARY REBECCA SHAWEN

3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widow

6.(b) Name of husband or wife Francis I. Shawen
(nee Wilcox)

7. Birth date of deceased (mo., day, yr.)

Sept. 5, 1854

6.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

9339

hrs.

min.

9. Birthplace Baltimore

(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER
MOTHER

12. Name

Wilcox

13. Birthplace _____

14. Maiden name _____

15. Birthplace _____

16. Informant

Mr. Edward Youse,

Address

501 Keyser Bldg.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

12/16/47

(month) (day) (year)

Cemetery or crematory

Old Balto. National Cem.

Location

Balto., Md.

18. Funeral director

WM. J. TICKNER & SONS

Address

Balto., Md.

19.

(Date rec'd by registrar)

Dec 16, 1947

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14, 1947, at _____ M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 1935 to 12/14 1947
 and that I last saw h. ex alive on 12/13 1947

Immediate cause of death

Arterio-sclerotic (under pressure)
stroke
(old age)

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

M. D. or other

Address

Date signed 12/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. We correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10995

Reg. Dist. No. 44

1. PLACE OF DEATH

County BaltimoreCity or town Sparrows Pt. Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Albert M. Simpson

3. (b) Social Security Number

4. Sex

M

5. Color or race

Wk.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Helen Mary Simpson

7. Birth date of deceased (mo., day, yr.)

January 4th, 1897

8. AGE:

Years

Months

Days

If less than one day

50115

hrs.

min.

9. Birthplace

Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

General Foreman,

11. Industry or business

Bethlehem Steell Co.

FATHER

12. Name

Isaac M. Simpson

13. Birthplace

Md.

MOTHER

14. Maiden name

?

15. Birthplace

?

16. Informant

Mrs. Helen Mary Simpson

Address

3018 Northern Parkway

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

12-12-47

(month) (day) (year)

Cemetery or crematory

Holy Redeemer

Location

Baltimore, Md.

18. Funeral director

Leonard J. Ruck

Address

5305 Harford Road, 14

19.

12/1019 47A.W. Hedrick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County ---City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3018 Northern

(If rural, give LOCATION)

2. (a) If veteran, name war ---

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec. 9th19. 47

at

10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. ---

to

19. ---and that I last saw h. --- alive on --- 19. ---

Immediate cause of death

Fractured Cervical Vertebrae

Due to

Fall from ladder crane

Due to

#1 open heart

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

NoneDate of op. ---

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide AccidentDate of 12/9/47

Where did injury occur?

Baltimore - Sp. - Baltimore

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) IndustryMeans of injury Fall from craneInjured at work? Yes

23. SIGNATURE

M. BrownAddress ---Date signed 12/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

10996

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County BaltimoreCity or town Halethorpe
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Post 3500 Ridge

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Halethorpe
(If outside city or town limits, write RURAL and give nearest town)Street No. 4313 Washington Blvd.

(If rural, give LOCATION)

2(a) If veteran, name war World War II

3. (a) FULL NAME

Benjamin H. Smith Jr.

3. (b) Social Security Number

4. Sex

male

5. Color or race

C

6. (a) Single, married, widowed, or divorced

single

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 47, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

DURATION

fractured skull

Due to.....

struck by automobile

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? Halethorpe Baltimore
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) public highwayMeans of injury struck by auto truck Injured at work? No23. SIGNATURE Ray M. Kieffer Baltimore

M. D. or other

Address 1010 Reed St. Date signed Dec 3 47

6. (b) Name of husband or wife.....

8. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 9-12-19228. AGE: Years 25 Months 2 Days 16 If less than one day..... hrs. min.8. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Benjamin H. Smith Jr.13. Birthplace Lynchburg, Virginia14. Maiden name Oral Sue Neal15. Birthplace Lynchburg, Virginia18. Informant Benjamin H. Smith Sr.Address 4313 Washington Blvd.17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 12-8-1947
(month) (day) (year)Cemetery or crematory Baltimore NationalLocation Baltimore18. Funeral director Katie SpillmanAddress 322 N Schreder St19. Dec 6 47 Ray M. Kieffer
(Date rec'd by registrar) (Registrar)18. Dec 3 4719. Dec 3 4719. Dec 3 47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE FLAIRLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

STATE OF WYOMING

DEPARTMENT OF HEALTH

RECEIVED
DEC 10 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10997

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.
City or town Near Boring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.
City or town Near Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3.(a) FULL NAME

Harriett E. Smith (Dett)

3.(b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Nelson Dett
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) May 10, 1873
8. AGE: Years 74 Months 7 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Balto. Co.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business _____

12. Name Joseph J. Smith

13. Birthplace Balto. Co.

14. Maiden name Frances Derricks

15. Birthplace Balto. Co.

16. Informant Josephine Diggs

Address Reisterstown, Md.

17. Burial Burial Date thereof Dec. 16, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Piney Grove

Location Balto. Co.

18. Funeral director J. F. Eline & Sons

Address Reisterstown, Md.

19. Dec. 16 - 19 47 Mary B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 19 47, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 11 19 47, to Dec. 14 19 47.

and that I last saw him alive on Dec. 13 19 47.

Immediate cause of death Branchio Pneumonia

DURATION

5 da.

Due to _____

Due to _____

Other conditions arteriosclerosis 2 gra

(Include pregnancy within 3 months of death)

Major findings of operation none Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE A. D. Caples, M.D. M. D. or other

Address Reisterstown, Md. Date signed 12-14-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15N

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 20 1947
BUREAU 9 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information requested. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

109

10998

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 years, 10 months, 20 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 23 years, 10 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war ?

3. (a) FULL NAME

George Sorrell

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife -
 7. Birth date of deceased (mo., day, yr.) 1889? 6.(c) If alive, give age years
 8. AGE: Years 58 Months ? Days If less than one day hrs. min.

9. Birthplace Virginia
 (Town, county, and state)
 10. Usual occupation Shipbuilder
 11. Industry or business Shipping
 12. Name ? Sorrell
 13. Birthplace ?
 14. Maiden name ?
 15. Birthplace ?

16. Informant Hospital records
 Address Catonsville-28, Md.
 17. Burial Date thereof Dec. 30, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory antioch
 Location Orange, Virginia
 18. Funeral director Harry H. Wigle
 Address 4101 Edmondson Ave
 19. 12/29 1947 A.W. Hadnail
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1947 at 11:55a M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 6 1924 to December 26 1947
 and that I last saw h. in alive on December 26 1947

Immediate cause of death Pneumonia, left
Cachexia; DURATION 24 hours
Indef.

Due to
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results Not done
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Isadore Fuert, M.D. M. D. or other
 Address Catonsville-28, Maryland Date signed 12-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10999

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
 City or town Long Green, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore
 City or town Long Green, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Int. Gion. A. M. E. Parsonage
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HANNAH

SPRATLEY

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife William E. Spratley
 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) January 28, 1882

8. AGE: Years 65 Months _____ Days _____ It less than one day _____ hrs. _____ min.

9. Birthplace Norfolk, Virginia
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George J. Wright

13. Birthplace Virginia

14. Maiden name Cecelia

15. Birthplace Virginia

16. Informant Rev. William E. Spratley

Address Int. Gion. A. M. E. Parsonage

17. Shipped Date thereof Dec. 16, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Norfolk, Virginia

18. Funeral director Mrs. Helen Williams

Address 322 N. Schenck St.

19. Dec 16, 1947 R. W. Hedrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 12, 1947 at 11⁰⁵ P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1946 to Dec. 12 1947

and that I last saw her alive on Dec. 12 1947

Immediate cause of death

Acute pulmonary edema

Due to Arteriosclerotic hypertensive

cardio-vascular disease

Due to Essential hypertension

Other conditions Obesity

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?)

Injured at work?

23. SIGNATURE George G. Merrill

M. D. or other

Address Baldwin Md. Date signed 12/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11000

Reg. Dist. No. 34

1. PLACE OF DEATH:

County BaltimoreCity or town Grave Run
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltoCity or town Grave Run
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Harry Mead Stevig

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

6. (b) Name of husband or wife

Lydia M. Stevig7. Birth date of deceased (mo., day, yr.) March 11-1868

6. (c) If alive, give age _____ years

8. AGE:

Years 79Months 8Days 27

If less than one day

_____ hrs. _____ min.

9. Birthplace

Maryland
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Ephraim Stevig

12. Name

Maryland

13. Birthplace

June Rowles

14. Maiden name

Maryland

15. Birthplace

Raymond Stevig

16. Informant

Maple Grove, Md

17. Burial

Dec 10/47

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Grave Run

Location

Balto Co, Md

18. Funeral director

Edw C Gipton

Address

Hamstead Md

19. Dec 10

19. 47 O. E. Foulk. Md.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1947 at 10:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 47to Dec 8 1947and that I last saw him alive on Dec 8 1947

Immediate cause of death

Coronary Thrombosis

DURATION

6 hrsDue to Coronary Artery Disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Maurice C. CarterAddress Hamstead, Md Date signed 12-8-47

M D or other

RECEIVED

DEC 13 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11001

30

Reg. Dist. No.

1. PLACE OF DEATH: County..... <u>Balto.</u> City or town..... <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... Hospital, institution, or street address where death occurred..... <u>Opitz Nursing Home - Nunnery Lane</u> How long in hospital or institution?.....				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... <u>Md</u> County..... City or town..... <u>Balto</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>2316 Cambridge St</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
3. (a) FULL NAME <u>John Taylor</u>				3. (b) Social Security Number <u>220-03-2325</u>			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Separated</u>			
6. (b) Name of husband or wife <u>Mary Taylor</u>				6. (c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>May 3rd 1875</u>				8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.			
9. Birthplace <u>Balto. Md.</u> (Town, county, and state)				10. Usual occupation <u>Laborer</u>			
11. Industry or business <u>Foot Canners</u>				12. Name <u>(Unknown) Taylor</u>			
13. Birthplace <u>"</u>				14. Maiden name <u>"</u>			
15. Birthplace <u>"</u>				16. Informant <u>Margaret Szymanski</u> Address <u>2316 Cambridge St.</u>			
17. Burial (Burial, cremation, or other) <u>Which?</u> Date thereof..... (month) (day) (year) <u>12/4/47</u> Cemetery or crematory..... <u>St. Stanislaus</u> Location..... <u>Balto. Md.</u>				18. Funeral director <u>William Cook Inc.</u> Address <u>1217 St. Paul St. Balto 2 Md.</u>			
19. 12-3 47 (Date rec'd by registrar)				20. DATE OF DEATH <u>Dec 15</u> 19 <u>47</u> at <u>4 P.</u> M			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Nov 25</u> 19 <u>47</u> to <u>Dec 1</u> 19 <u>47</u> and that I last saw him/her alive on <u>Dec 1</u> 19 <u>47</u>				Immediate cause of death <u>Cerebral Hemorrhage</u>			
Due to <u>arteriosclerosis</u>				DURATION <u>3 days</u>			
Due to				Other conditions			
(Include pregnancy within 3 months of death)				Major findings of operations			
Autopsy results				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town)..... (County)..... (State)..... Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....				23. SIGNATURE <u>Reese Howes</u> M. D. or other..... Address..... Date signed.....			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11003

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Md.
 How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2544 Floyd Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I

3. (a) FULL NAME

JOHN G. THARLE

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife Single
 7. Birth date of deceased (mo., day, yr.) 8-4-88 8.(c) If alive, give age _____ years
 8. AGE: Years 59 Months 4 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business _____

12. Name Thomas Tharle

13. Birthplace Maryland

14. Maiden name Ella Neuman

15. Birthplace Cumberland, Md.

16. Informant Clinical Records, Vets. Adm. Hosp.
Ft. Howard, Md.
 Address _____

17. Burial Date thereof 12/23/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Fredrick Road

18. Funeral director Howard M. Blight Jr.

Address 4914 Belair Road

19. 12/23/47 A.W. Hedrick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20, 19 47 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15, 19 47, to December 20, 19 47, and that I last saw him alive on December 20, 19 47.

Immediate cause of death Tetanus
 DURATION 5 da.

Due to _____

Due to _____

Other conditions Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James B. Parker, M.D.

Address VAH Ft. Howard, Md. Date signed _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11004

1. PLACE OF DEATH:

County... Bald.
 City or town... Relay
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred: Gun Rd.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... md. County... Bald.
 City or town... Relay
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Gun Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3.(a) FULL NAME

Mary Thirlkel

3.(b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widow
 6.(b) Name of husband or wife Late James A. Thirlkel
 6.(c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) July 6, 1866
 8. AGE: Years 81 Months 5 Days 17 If less than one day
 ...hrs. ...min.

9. Birthplace Ind. (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name Unk. Getz
 13. Birthplace Germany
 14. Maiden name Unk.
 15. Birthplace Germany

16. Informant Mrs Benjamin H. Anderson
 Address Gun Rd. - Relay, Md.
 17. Burial Date thereof 12/26/47.
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Landon Pk.
 Location 3801 Frederick Road.
 18. Funeral director Harry H. Withke
 Address 4101 Edmondson Ave

19. 12/26 19 47 R.W. Hedrick
 (Date rec'd by registrar) (month) (day) (year) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/47. 19... at 4:35 P.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 20 19 47 to Dec 23 19 47
 and that I last saw her alive on Dec 20 19 47
 Immediate cause of death Broncho-pneumonia DURATION 3 da.
 Due to Myocardial 6 mo
infarction
 Due to Senile 3-70
arteriosclerosis
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op. ...

Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of ...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE R. W. Hedrick M. D. or other
5609 Main St
 Address Elbridge Md. Date signed 12/24/47

July 45

June 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11002

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Baltimore
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 52 yrs
Hospital, institution, or street address where death occurred:
Park Hts & Walnut Aves Owings Mills
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No. Park Heights & Walnut Aves
(If rural, give LOCATION)
World War 1
2.(a) If veteran, name war ✓

3. (a) FULL NAME

Charles Gilbert Tillman

3. (b) Social Security Number

none

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced M

6. (b) Name of husband or wife Theresa Springmann
Tillman 6. (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) January 26 1895

8. AGE: Years 52 Months 11 Days 3 If less than one day - hrs. - min.

9. Birthplace Owings Mills Balto Co Md
(Town, county, and state)

10. Usual occupation Storekeeper

11. Industry or business II

12. Name Charles Richard Tillman

13. Birthplace Oakland Carroll Co Md

14. Maiden name Emma Johnson

15. Birthplace Sweden

16. Informant Mrs Charles G Tillman

Address Park Hts & Walnut Aves Owings Mills Md

17. Burial Carroll's Chapel Cemetery Date thereof Jan 1 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Owings Mills Md

Location Wm Berryman & Sons

18. Funeral director Reisterstown Md

Address Reisterstown Md

19. Dec-30-47 Mary B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1947 at 6:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-29-47 to 12-29-47 and that I last saw him alive on not seen alive 19-

Immediate cause of death Coronary Artery Disease DURATION Instant

Due to Arteriosclerotic C.V. Disease 4 yrs

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations NONE Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NONE Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE Dr. D.D. Caples Med. Exam M. D. or other -

Address Reisterstown, Md. Date signed 12-30-47

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED
JAN 3 1948
RETURNED TO SENDER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

53

CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH:

County... BaltimoreCity or town... Jessas
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... BaltimoreCity or town... Jessas
(If outside city or town limits, write RURAL and give nearest town)Street No. Church Lane
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Eugene A. Tracey

3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Mary A. (Garrick)

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

April 11, 1866

8. AGE:

Years

Months

Days

If less than one day

81725

hrs.

min.

9. Birthplace

Balto Co., Md.
(Town, county, and state)

10. Usual occupation

General Laborer

11. Industry or business

FATHER

12. Name

Wm. Tracey

13. Birthplace

Pennsylvania

MOTHER

14. Maiden name

Elizabeth Hallion

15. Birthplace

Unknown

16. Informant

Gerald Quinn

Address

Jessas, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof... Dec 9, 1947
(month) (day) (year)

Cemetery or crematory

St. Joseph

Location

Jessas, Maryland

18. Funeral director

Landon M. Brooks

Address

Jessas, Md.

19.

Dec 9, 1947
(Date rec'd by registrar)Wilmer C. Ensor

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Dec 6 19 47 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 15 19 42 to Dec 6 19 47and that I last saw him alive on 12/5 19 47

Immediate cause of death

Carcinoma -
(Right chest mastoid) 3 yrs

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wilmer C. Ensor M.D.
M. D. or otherAddress... Corcheyville Md. Date signed Dec 7/47

MARGIN RESERVED FOR BINDING

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 12 1947
ST. LOUIS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11006

Reg. Dist. No. 198 30

1. PLACE OF DEATH:

County..... Baltimore
 City or town..... Baltimore 7
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Baltimore
 City or town..... Johnnycake Road
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Baltimore, 7
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

CHARLES W. TUCKER

3. (b) Social Security Number

4. Sex..... Male
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Widowed

6.(b) Name of husband or wife..... Elizabeth Tucker
 deceased

7. Birth date of deceased (mo., day, yr.)..... May 25, 1866
 8.(c) If alive, give age..... years

8. AGE: Years 81 Months 6 Days 29 It less than one day
 hrs. min.

9. Birthplace..... Carroll Co. Md.
 (Town, county, and state)
 10. Usual occupation..... Merchant

11. Industry or business..... retired

12. Name..... UNKNOWN

13. Birthplace.....

14. Maiden name..... UNKNOWN

15. Birthplace.....

16. Informant..... Mr. Truman B. Tucker

Address..... Baltimore Md. 7

17. Burial..... 12-27-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Taylorsville
 Location..... Taylorsville, Carroll Co. Md.

18. Funeral director..... C.M. Waltz
 Address..... Winfield, Md.

19. 12-27-47 47 E. Paul Quinn
 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 24, 1947, at 7:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 4, 1947, to Dec. 24, 1947, and that I last saw him alive on Dec. 22, 1947.

Immediate cause of death..... Cerebral hemorrhage
 DURATION.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... J. E. Martin M. D. or other

Address..... Randallstown Date signed 12/24/47

RECEIVED
DEC 30 1947
FIVE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 92a
 11007
 33
 Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore
 City or town Carmy Mills, Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 yrs 10 mo 10 days
 Hospital, institution, or street address where death occurred:
18 yrs 10 mo 10 days
 How long in hospital or institution? 18 yrs 10 mo 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1439 Conway St.
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

3. (a) FULL NAME

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 12/27/47 10/25/21
 (c) If alive, give age _____ years

8. AGE: Years 26 Months 2 Days 9 11 hrs. 11 min. 7

9. Birthplace Baltimore Md.
 (Town, county, and state)

10. Usual occupation Inmate, Rosewood

11. Industry or business

12. Name John Ulrich

13. Birthplace Md.

14. Maiden name May Butler

15. Birthplace Md.

16. Informant Institutional record

Address Carmy Mills, Md.

17. BURIAL Date thereof 12/30/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CEDAR HILL

Location PITCHER HIGHWAY

18. Funeral director JOHN F DENNY, INC.

Address 715 LIGHT ST

19. 12/30/47 19 _____
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Dec 19 47 at 2:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 Dec 19 47 to 27 Dec 19 47
 and that I last saw him alive on 25 Dec 19 47

Immediate cause of death _____ DURATION _____

Cardiac Insufficiency
(Coronary Artery Disease)
 Due to _____

Due to Broncho-Pneumonia 1 day
Acute bronchitis 2 days

Other conditions Chronic media suppuration 12 yrs
tubercular
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Harry B. Butler, Md. M. D. or other
Carmy Mills, Md. Date signed 12/30/47
 Address _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11008938

1. PLACE OF DEATH:
 County Baltimore
 City or town Towson 4, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since Oct 26, 1947
 Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson 4, Maryland
 How long in hospital or institution? Since Oct 26, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore City
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1924 W. Saratoga St
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME Clara E Wayland

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 21, 1882 8. (c) If alive, give age _____ years

8. AGE: Years 65 Months 4 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Howard County, Md
 (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business

12. Name Fred Wayland13. Birthplace Howard County Md14. Maiden name Clara E. Askey15. Birthplace Baltimore Md

Personal History - Hospital Records

16. Informant

Address Eudowood Sanatorium, Towson 4, Md.17. Burial Date thereof Dec 31, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid RidgeLocation Pikesville Ind18. Funeral director Harry H. WitzkeAddress 4101 Edmonson Ave19. Dec 22 1947 19 47 J. D. Delaney
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1947 at 5:15 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 26 1947 to Dec 28 1947and that I last saw him alive on December 27 1947

Immediate cause of death _____ DURATION

Pulmonary tuberculosis

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE W. A. Bridges M. D. or otherAddress Towson 4, Md. Date signed 12-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11009

Reg. Dist. No. 30

1. PLACE OF DEATH:

County CATONSVILLE MD.
 City or town EDMONDSON AVE & NUNERY LANE
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD. County -
 City or town BALTIMORE MD.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5703 CROSS COUNTRY BLVD.
 (If rural, give LOCATION)
 2.(a) If veteran, name war No ☒

3. (a) FULL NAME

ALICE VICTORIA WEEKS

3. (b) Social Security Number

No

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

WIDOWED

6. (b) Name of husband or wife

JAMES H. G. WEEKS

7. Birth date of deceased (mo., day, yr.)

SEPT 26, 1864

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

It less than one day

83

3

5

hrs.

min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

HOME

FATHER

12. Name

CHARLES E. FAIRBANK

13. Birthplace

MARYLAND

MOTHER

14. Maiden name

ELIZABETH J. HALE

15. Birthplace

MARYLAND

16. Informant

MR. WALTER E. WEEKS - SON

Address

5703 CROSS COUNTRY BLVD.

17.

(Burial, cremation, or removal. Which?)

Date thereof

1/3/48

(month) (day) (year)

Cemetery or crematory

LORRAINE

Location

BALTO. MD.

18. Funeral director

WM. J. TURNER & SONS INC.

Address

NORTH TA. BALTO. MD.

19.

(Date rec'd by registrar)

19

48

A. W. Hedrick

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 31 1947 at 11⁰⁰ A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

DEC 26 1947 to DEC 31 1947and that I last saw h..... alive on DEC 31 1947

Immediate cause of death

Pericardial hemorrhage 2 days

DURATION

Due to

Acute Pericarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Manner of injury

Injured at work?

23. SIGNATURE

James H. Weeks

M. D. or other

Address

Date signed

1/2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11810 10

1. PLACE OF DEATH:

County BaltimoreCity or town Hotel Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Hotel Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Sister Mary Edwardine Wehr

3.(b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 18638. AGE: Years Months Days If less than one day
84 2 17 hrs. min.9. Birthplace Baltimore
(Town, county, and state)10. Usual occupation Teacher

11. Industry or business _____

12. Name Father Wehr13. Birthplace Germany14. Maiden name Eva Hepp15. Birthplace Germany16. Informant Sr. Mary ClaraAddress Hotel Cliff, Md17. (Burial, cremation, or removal. Which?) Burial Date thereof Dec 29/47
(month) (day) (year)Cemetery or crematory Hotel CliffLocation Blessed Ann18. Funeral director Rev. M. J. SmithAddress 811 N. Wolfe St19. (Date rec'd by registrar) 12/28/47 Registrar J. J. H. H. H.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1947, at 6:05 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 1944, to Dec 27 1947and that I last saw him alive on Dec 22 1947

Immediate cause of death _____

Pneumonia - Pneumonia DURATION 2 weeks

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE _____ M. D. or other

Address _____ Date signed _____

RECEIVED

JAN 5 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... BaltimoreCity or town..... Reisterstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... BaltimoreCity or town..... Reisterstown
(If outside city or town limits, write RURAL and give nearest town)Street No..... 33 Bond Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

CARRIE DOUGLAS WELCH

3. (b) Social Security Number

4. Sex..... <u>Female</u>	5. Color or race..... <u>Colored</u>	6. (a) Single, married, widowed, or divorced..... <u>Married</u>
------------------------------	---	---

8. (b) Name of husband or wife..... John T.7. Birth date of deceased (mo., day, yr.)..... July 6, 1870
6. (c) If alive, give age..... years

8. AGE: Years..... <u>77</u>	Months.....	Days.....	If less than one day..... hrs. min.
---------------------------------	-------------	-----------	--

9. Birthplace..... Waterford, Virginia
(Town, county, and state)10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... Marshall Claggett13. Birthplace..... Waterford, Virginia14. Maiden name..... Unknwn

15. Birthplace.....

18. Informant..... John T. WelchAddress..... 33 Bond Ave.17. Burial Date thereof..... December 19,
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... St. LukesLocation..... Reisterstown, Maryland.18. Funeral director..... Mrs. George H. HollandAddress..... 1631 Druid Hill Ave.19. 12-18-47 (Date rec'd by registrar) 19. 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec 16 19. 47 at 10:20 A.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
10-7 19. 47, to 12-16 19. 47.and that I last saw her alive on 12-15-47 19. 47.Immediate cause of death..... Metastatic Ca. of Liver
DURATION..... 3 mo.Due to..... Ca. of Breast
DURATION..... 6 mo.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... S. D. Exley M. D. or otherAddress..... Reisterstown, Md. Date signed..... 12-18-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:

County BALTO.City or town SPARROWS POINT
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 33 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)Street No. 917 F Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

EARL W. WELLINGS

3. (b) Social Security Number

4. Sex M 5. Color or race White 6.(a) Single, married, widowed, or divorced Married8.(b) Name of husband or wife Caroline E. Wellings

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) September 5, 18888. AGE: Years 59 Months 3 Days 24 If less than one day _____ hrs. _____ min.9. Birthplace Waynesboro, Pa.
(Town, county, and state)10. Usual occupation Iron Moulder11. Industry or business Bethlehem Steel Co.12. Name George Wellings13. Birthplace Pennsylvania14. Maiden name Ida15. Birthplace Pennsylvania16. Informant Mrs Milton E. BladesAddress 917 F Street, Sparrows Point17. Burial Date thereof Jan 2, 1947
(Burial, cremation, or removal, Which) (month) (day) (year)Cemetery or crematory OaklawnLocation Eastern Boulevard, Balto. Co.18. Funeral director Roland L. FisherAddress 2112 Dunsdale Ave19. 12-29-47 19 12-29-47
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29-47 19____ at 3:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Coronary OcclusionDue to Hypertensive C-V Disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? Home
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE M B Davis MDSupt. Med. Examiner BaltimoreAddress Dundalk, Md. Date signed 12-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 7 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 83 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Fort Howard, Md.How long in hospital or institution? 83 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 3507 Walbrook Ave.
(If rural, give LOCATION)2.(a) If veteran, name war WW I

3. (a) FULL NAME

WILLIAM B. WHALEY

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MaleWhiteSingle6.(b) Name of husband or wife Single7. Birth date of deceased (mo., day, yr.) 9-30-89

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
58 2 29 hrs. min.9. Birthplace Oxford, Maryland
(Town, county, and state)10. Usual occupation Oil Loader

11. Industry or business

12. Name William Whaley
13. Birthplace Centerville, Md.14. Maiden name Mary E. Saidler15. Birthplace St. Michaels, Md.16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 1/2/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid Ridge CemeteryLocation Baltimore, Md.18. Funeral director William J. Tickner & SonAddress North & Penna. Ave. Baltimore, Md.19. 1/2 48 A.W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 19 47 at 6:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
October 7 19 47 to December 29 19 47and that I last saw him alive on December 29 19 47

Immediate cause of death

BACTERIAL ENDOCARDITISDURATION
2 1/2 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Donnis M. Bualson
M. D. or otherAddress V.A.H. Fort Howard, Md. Date signed 12-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11014

Reg. Dist. No. 31

1. PLACE OF DEATH:

County BaltimoreCity or town Mt. Restistown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 Months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Mt. Restistown
(If outside city or town limits, write RURAL and give nearest town)Street No. Nicodemus & Cherry Hill Roads
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Elizabeth Wheat

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Robert Wheat7. Birth date of deceased (mo., day, yr.) Dec. 16, 1863 6.(c) If alive, give age 7 years8. AGE: Years 83 Months 11 Days 16 If less than one day
hrs. min.9. Birthplace MD
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Robert Wheat13. Birthplace MD14. Maiden name Catherine O'Brien15. Birthplace MD16. Informant Mrs. Robert WheatAddress Nicodemus & Cherry Hill Rd., Restistown17. Burial Date thereof Dec. 5, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Olive CemeteryLocation Randallstown, Md.18. Funeral director C. Harry WeirAddress Hygherville, Md.19. 12/2/47 1947 Tom E. Martin
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 5 1947 to Dec 2 1947and that I last saw him alive on Dec. 2 1947

Immediate cause of death

Cerebral hemorrhage DURATION 1 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Tom E. Martin M. D. or otherRandallstown Date signed 12/2/47

RECEIVED

DEC 22 1947

BUREAU P C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information requested. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

11015

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 years, 7 months, 22 days
 Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
 How long in hospital or institution? 11 years, 7 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1035 Boyd Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

WHEELTON, Mary

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Leonard Wheelton

7. Birth date of deceased (mo., day, yr.) March 25, 1893 6.(c) If alive, give age _____ years

8. AGE: Years 54 Months 9 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Housework12. Name Ryan Duvall13. Birthplace Maryland14. Maiden name Virginie Wilson15. Birthplace Maryland16. Informant Hospital recordsAddress Catonsville- 28, Maryland.

17. Burial Date thereof 1-7-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Grove State HospitalLocation Catonsville 28, Md.18. Funeral director Spring Grove State HospitalAddress Catonsville 28, Md.

19. 1/10 48 A.W. Helnick
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1947 at 5:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5, 1936 1947, to December 27, 1947 and that I last saw him alive on December 27, 1947

Immediate cause of death Arteriosclerotic heart disease; Coronary thrombosis. DURATION Indef. Indef.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

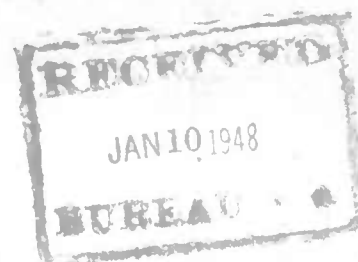
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Isadore Tuerk, M.D. M. D. or otherAddress Catonsville-28, Maryland Date signed 12-29-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:

County.....

City or town..... ARBUTUS, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1239 VOGT AVE

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD..... County.....City or town..... ARBUTUS, MD.
(If outside city or town limits, write RURAL and give nearest town)Street No. 1239 VOGT AVE
(If rural, give LOCATION)2.(a) If veteran, name war..... No

3. (a) FULL NAME

HENRY WEITZEL JR.

3. (b) Social Security Number

212-16-9382

4. Sex

M

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

MARRIED6.(b) Name of husband or wife..... REBECCA NEE BERKENHEIMER

7. Birth date of deceased (mo., day, yr.)

JULY 9, 1871

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

76513

hrs.

min.

9. Birthplace..... BALTIMORE, MD.
(Town, county, and state)10. Usual occupation..... WATCHMAN11. Industry or business..... HUTZLER BROS12. Name..... HENRY WEITZEL13. Birthplace..... MD.14. Maiden name..... HELEN LIPS15. Birthplace..... GERMANY16. Informant..... MRS. HENRY WEITZEL JR.Address..... 1239 VOGT AVE, ARBUTUS, MD.17. CREMATION
(Burial, cremation, or removal. Which?) Date thereof..... 12/26/47
(month) (day) (year)Cemetery or crematory..... GREENMOUNT CREMATORYLocation..... BALTIMORE, MD.18. Funeral director..... W.M. J. TICKNER & SONS, INC.Address..... NORTH 4th Ave., BALTO, MD.19. 12/26 19 47
(Date rec'd by registrar)J.W. Hedrich
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... DEC 22 19 47, at 11:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1 19 47, to Dec 22 19 47and that I last saw Dec 21 19 47Immediate cause of death..... myocardial infarction

DURATION

3 daysDue to..... Cerebral thrombosis3 daysDue to..... Coronary vascular disease1Other conditions..... myocardial infarction1

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... Dr. J. M. Kieffer M. D. onAddress..... 1010 Lehigh Ave. Date signed..... 12-24-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County Balto
City or town 1500 Eastern Ave Rd
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltoCity or town Essex # 21
(If outside city or town limits, write RURAL and give nearest town)Street No. 1500 Eastern Ave Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Wick (Wick)

3. (b) Social Security Number

4. Sex M. 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1861 8.(c) If alive, give age8. AGE: Years 86 Months Days If less than one day
.....hrs.min.9. Birthplace Germany
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name Geo. Wick13. Birthplace Germany14. Maiden name Barbara Deuerling15. Birthplace Germany16. Informant Henry WickAddress 1500 Eastern Ave Rd17. Burial Date thereof 12-10-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Ignored Heart of JesusLocation Balto18. Funeral director J. B. BrownAddress 1407 Eastern Ave Rd19. 12/9 1947 A. W. Heuch
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 19 47 at 5:40A..M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 19 47 to Dec 7 19 47 and that I last saw him alive on Dec 7 19 47Immediate cause of death Coronary ThrombosisDURATION SuddenDue to Arterio-Sclerotic
Cardio-Vascular Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. M. Baumgardner M. D. or otherAddress Balto 6 Md Date signed 12-7-47

MARGIN RESERVED FOR BINDING

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11017

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore
 City or town Fort Howard
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 Days
 Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Fort Howard, Maryland
 How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County _____
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2696 St. Benedict St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war WW-I

3. (a) FULL NAME

HENRY F. WIEBER

3. (b) Social Security Number

213-03-0668

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Barbara Wieber
 6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 2-18-94
 8. AGE: Years 53 Months 9 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Baltimore, Md.
 (Town, county, and state)

10. Usual occupation Turn Leader

11. Industry or business Rustless Iron & Steel Co.

12. Name Joseph Wieber

13. Birthplace Albany, New York

14. Maiden name Anna Wieber (Huffmeister)

15. Birthplace Baltimore, Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.
Fort Howard, Maryland
 Address _____

17. Burial Date thereof 12-4-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meadowridge

Location Howard County, Md.

18. Funeral director George L. Schwalb

Address 2101 Frederick Ave. Balto. Md.

19. 12/4 47 A. W. Hedrich
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 19 47 at 4:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 27, 19 47 to December 1, 19 47
 and that I last saw him alive on December 1, 19 47

Immediate cause of death Subacute Nephritis, cause unknown DURATION Unknown

Due to _____

Due to _____

Other conditions Hypertension, cause Unknown Unknown
Uremia, due to Nephritis, Unknown
Tuberculosis, pulmonary, apical, mod.

Major findings of operations Duration, Unknown

Autopsy results Substantiated above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE George E. Snider GEORGE SNIDER, M.D. M. D. or other _____

Address V.A.H. Ft. Howard, Md. Date signed 12-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 87

1. PLACE OF DEATH:

County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)Street No. 6813 Holabird Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Catherine Wills

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife William H. Wills6.(c) If alive, give age 64 years7. Birth date of deceased (mo., day, yr.) November 14, 1883

8. AGE: Years Months Days It less than one day

64 0 25 hrs. min.9. Birthplace Baltimore, Md.
(Town, county, and state)10. Usual occupation At home

11. Industry or business

12. Name John Ledekar13. Birthplace Germany14. Maiden name Ulk15. Birthplace Germany16. Informant Catherine DietzAddress 327 S. Macon St-2417. Burial Date thereof Dec 12, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak LawnLocation City18. Funeral director Wesley Funeral HomeAddress 2008 Orleans St19. 12-12-47 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1947 at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death Coronary Occlusion DURATION 5 minsDue to ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M B Davis M DAddress Dundalk, Md Date signed 12/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. *Anderson*BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATHRegistered No. *11019*

1. PLACE OF DEATH

- (a) Baltimore *City*, Maryland
- (b) Street address *6801 Belair Road*
- (c) Hospital or institution:
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

- (a) State *Md.* (b) County *BALTIMORE*
- (c) City or town *Baltimore*
(If outside city or town limits, write RURAL and give town)
- (d) Street No. *6801 Belair Road*
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME

James A. Woodward

3 (b) If veteran, name war

3 (c) Social Security Account
No.

4. Sex male	5. Color or race white	6 (a) Single, married, widowed, or divorced. widowed
----------------	---------------------------	---

6 (b) Name of husband or wife *Susan H.*

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *July 14, 1859*

8. AGE: Years 88	Months 5	Days 11	If less than one day hr. min.
---------------------	-------------	------------	----------------------------------

9. Birthplace *Calcutta, India*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *?*13. Birthplace *?*14. Maiden Name *?*15. Birthplace *?*16 (a) Informant *Mr. Alex. Woodward*(b) Address *6801 Belair Road, #6*

17 (a) *Burial* (b) Date thereof *12-29-47*
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Moreland Park*
Location *Baltimore*

18 (a) Funeral director *Leonard J. Ruck*(b) Address *5305 Harford Road, 14*

19 (a) *DEC 27 1947* (b) *Walter A. Anderson*
(Date rec'd by registrar) (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH *Dec. 25th* 19*47*, at *M*

21. I certify that death occurred on the date above stated; that I attended deceased from *Dec 6* 19*46* to *Dec 25* 19*47*, and that I last saw him alive on *Dec 24* 19*47*.

Immediate cause of death

Coronary occlusion

Due to

Arterio-sclerosis

Due to

Other Conditions

Senility

(Include pregnancy within 8 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence _____ at _____ M
- (c) Where did injury occur? _____
(City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____
(Specify type of place)

(e) Means of injury

23. Signature *Walter A. Anderson*Address *3001 Shannon Drive* Date signed *12/26/47*

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *ky*

11020

1. PLACE OF DEATH *Baltimore - 19.*
 County.....
 City or town..... *Sparrows Point*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *14 months*
 Hospital, institution, or street address where death occurred:
7308 Bay Front Rd.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... County.....
 City or town..... *see in # 1*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2. (a) If veteran, name war.....

3. (a) FULL NAME

ANNA J. YINGLING.

3. (b) Social Security Number

none

4. Sex *Female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *Widowed*

6. (b) Name of husband or wife *David R Yingling*
 B. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) *Nov. 27, 1870*

8. AGE: Years *77* Months *0* Days *15* If less than one day..... hrs. min.

9. Birthplace..... *Westminster, Md.*
 (Town, county, and state)

10. Usual occupation..... *Housework*

11. Industry or business..... *iron house*

12. Name..... *Isaac Renavitt*

13. Birthplace..... *Germany*

14. Maiden name..... *unknown*

15. Birthplace.....

16. Informant..... *James E. Yingling*

Address..... *see in # 1*

17. (Burial, cremation, or removal. Which?) *Burial* Date thereof..... *12-15-1947*
 (month) (day) (year)

Cemetery or crematory..... *OAK LAWN CEM.*

Location..... *EASTERN AVE EXT.*

18. Funeral director..... *LILLY & ZEILER INC.*

Address..... *403 S. WOLFE ST.*

19. *12-15* 19 *47* *D. W. Hedrick*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Dec. 12* 19 *47* at *2 P.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Oct.* 19 *46* to *Dec. 2* 19 *47*

and that I last saw him alive on *Dec. 2* 19 *47*

Immediate cause of death..... *Septicemia*

General arteriosclerosis 15 yrs.

Due to..... *Infection*

Due to..... *pleuropneumonia*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... *none*

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... *Louis D. Tullin M.D.*

Address..... *908 N. Pratt Rd. Balt. 14*

Date signed..... *12/12/47*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1102130

1. PLACE OF DEATH:

County Baltimore
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months
 Hospital, institution, or street address where death occurred:
Good Nursing Home
 How long in hospital or institution? North Bend + Edmonson

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Garrison, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Smiths Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Elessia Zertho

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Edward Frederick Zertho
Deceased 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years about 65 Months Days If less than one day
 hrs. min.

9. Birthplace Germany
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Emma H. Newell

Address Pikesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 1/3/47
 (month) (day) (year)

Cemetery or crematory Mt. Olive

Location Randallstown, Md.

18. Funeral director Paul H. Newell

Address Pikesville, Md.

19. Date rec'd by registrar Jan 3 1948 Registrar C. H. Bedrick
add

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 December 1947, at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
11 September 1947, to 31 Dec 1947
 and that I last saw him alive on 31 Dec 1947

Immediate cause of death Carcinoma of X. breast with metastases
 DURATION 1-2 years

Due to.....

Due to.....

Other conditions cardiac failure

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma of X breast
 Date of op. 1946

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE John A. Hester Jr. M. D. or other

Address 20 E. Preston St., Balt 2 Date signed 2 Jan 48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Nesbit